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ABSTRACT

This monograph is an international overview of available information about the current status of rehabilitation efforts for the mentally ill. It served as a springboard for discussion at the Special Interest Group session at the Fourteenth World Congress of Rehabilitation International in Winnipeg, Canada, on June, 1980. The first part of the monograph introduces the international context of rehabilitation of the mentally ill and outlines the scope of the problem. In Part 2, two areas of interest to those working in rehabilitation of the mentally ill are surveyed: laws about mental illness and mental patients, rights and responsibilities, in various countries of the world; and rehabilitation procedures for treating the mentally ill in various cultures and countries. Part 3 suggests prospects for the future--collaborative efforts that could be made among nations and international organizations in disseminating information about rehabilitation procedures; and a summary of the needs of rehabilitation programs. A list of references is included. (KC)

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Rehabilitation of the Mentally Ill: An International Perspective

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Part One: Introduction

The ever-growing realization of the importance of an exchange of ideas on a national as well as an international scale is written into the 1978 Rehabilitation, Comprehensive Services, and Developmental Disabilities Amendments to the Rehabilitation Act of 1973 in the United States of America. At the national level, a new Interagency Committee has been established as follows:

> Sec. 203.(a)(1) In order to promote coordination and cooperation among Federal departments and agencies conducting rehabilitation research programs, there is established within the Federal Government an Interagency Committee on Handicapped Research...chaired by the Director and comprised of such members as the President may designate, including the following...: the Director, the Commissioner, the Commissioner of Education, the Administrator of Veterans' Affairs, the Director of the National Institutes of Health, the Administrator of the National Aeronautics and Space Administration, the Secretary of Transportation and the Director of the National Science Foundation.

On the international scale, the Act focuses research, demonstration and training efforts as follows:

> Sec. 204.(b)(5) Conduct a program for international rehabilitation research, demonstration, and training for the purpose of developing new knowledge and methods in the rehabilitation of handicapped individuals in the United States, cooperating and assisting in developing and sharing information found useful in other nations in the rehabilitation of handicapped individuals in the United States, and initiating a program to exchange experts and technical assistance in the field of rehabilitation of handicapped individuals with other nations as a means of increasing the levels of skill of rehabilitation personnel.

There are precedents for international exchange in many areas of endeavor by the United States. For instance, the International Research and Demonstration Projects of the Agricultural Trade, Development and Assistance Act, as Amended P.L. 480.

Since 1961, the Social and Rehabilitation Service (SRS), the Rehabilitation Services Administration (RSA), and their predecessor agencies, particularly the Welfare Administration, have been engaged in cooperative research and demonstration with a number of developing countries... under the Special Foreign Currency Program, authorized by Public Law 480, The Agricultural Assistance Act of 1954, as amended (*SRS and RSA, 1976*).*

Recently, in order to implement the 1978 Amendment (Sec. 204(b)(5)), the World Rehabilitation Fund (WRF) instituted the International Exchange of Information in Rehabilitation project designed to facilitate the sharing of rehabilitation information transnationally—focusing on the identified knowledge gaps in the United States. Of particular pertinence to the interests of this monograph is the fact that the second monograph in the WRF series discusses rehabilitation procedures for chronic schizophrenics in Sweden (*Dencker, 1980*).

These initiatives by the United States towards international collaborative undertakings are prodded from still another direction—by identifiable gaps in the service system for the mentally ill in both the developed and developing countries. From its inception, the concept of rehabilitation has been linked primarily to physical disabilities. Thus a serious void occurs in recognizing that for the mentally ill—curative processes are not enough. Dr. Gerald Klerman, Administrator, Alcohol, Drug Abuse and Mental Health Administration, recently commented that in the 1950's there were approximately 600,000 patients in public mental health hospitals. New forms of psychosocial technology plus the advent of neuroleptics gave impetus to the release of institutionalized patients so that today there are less than 120,000 in the United States public mental hospitals. Thus the length of hospitalization has been shortened and the "patients are better but not well... we are suffering from partial success."

It is not sufficient that psychopharmacology and other techniques have decreased (or masked) the vigor of the symptoms so that these patients are not dangerous to themselves or others. They must be helped to achieve, as close as possible, their potential level of independence—in community residential arrangements, economic self-sufficiency, and, if desirable, return to a social place within their families. In other words, these "restored" individuals must accomplish social integration within the community. This goal suggests that there is a triad of rehabilitation needed—the person, the family, and the community.

The lack of recognition and emphasis on the significance of rehabilitation is often the crux of the problem for the mentally ill person. The literature about prevention, diagnosis, therapeutic

*The special Foreign Currency Program provides for financing of research and demonstration projects with U.S.-owned foreign currencies generated by the sale of U.S. agricultural commodities, which exceed amounts needed by the U.S. government for meeting Embassy and other primary requirements. Thus participation by the developing countries in this program is designated by the U.S. Department of the Treasury. Additional requirements are that applicants for funds under the program (governmental and private non-profit institutions) present sound research or demonstration proposals addressing problems of mutual concern to both the U.S. and applicant governments and that these proposals are officially sanctioned by the respective governments (SRS and RSA, 1976).

measures has been abundant. However the mention of the fourth aspect, namely rehabilitation, is only beginning to seep through discussions. This lag is apparent in the United States as well as in most other countries. The theoretical foundations and practical applications of rehabilitation with the physically handicapped is one source of information. However, there are many other world resources that can be made available.

No one country has all of the answers. No one country can fulfill the perfect prototype for other countries. (*N.V.G.A., 1978*). Both developed and developing countries would profit from an exchange of information. Intensified efforts are emerging to rectify the gaps in the continuum of services for the mentally ill. These efforts are directed to the system of services with particular emphasis on the deficiencies in rehabilitation procedures. One outcome has been the origination of an international non-governmental consortium to be known as the *World Association for the Rehabilitation of the Psycho-socially Disabled*. This Association will be affiliated with *Rehabilitation International* as an International Association Affiliate. The overall mission of the Association is "advocating for the medical, social, and vocational rehabilitation needs of the psycho-socially disabled"(Policy Statement, 1980). A special leadership meeting was convened in Geneva, Switzerland, in January 1980 by Dr. Nathan Kline and Irving Blumberg, President and Executive Vice President, respectively, of the International Committee Against Mental Illness. Deliberations at this meeting supported the need for an organization specifically designed to emphasize the rehabilitation processes essential, as de Chardin* states it: "a future consisting not merely of successive years but of higher states to be achieved."

Bernard Posner, Executive Director of the President's Committee on Employment of the Handicapped, a participant at the Geneva meeting, suggested that an international overview of available information about the current status of rehabilitation for the mentally ill might provide the springboard for discussion at the Special Interest Group sessions on June 24, 1980 at the Fourteenth World Congress of Rehabilitation International in Winnipeg, Canada. This monograph is the product of these considerations.

In order to be available for the June, 1980 meetings in Canada in time for the deliberations, the tight schedule demanded an overview and brevity of reporting. Furthermore, secondary data from interviews, monographs, periodicals and other references have provided the majority of information for the content of this monograph. Lack of comprehensiveness due to the need for brevity and the possibility of bias ensuing from selective perception may have eventuated in unintentional inaccuracies. These are the caveats of which the reader should be mindful in the survey contained in Part II of the monograph: *State of the Art Internationally*.

*de Chardin, T.T., The future of man, New York: Harper and Row Publishers, Inc., 1964.

The three primary sources that provided particulars for the survey of international organizations and of countries are: l) International Sources, 2) National (United States) sources, 3) A literature search. Appreciation for assistance in this research can only be partially expressed in a listing of acknowledgements. Additionally, there is always the fallacy of omission that besets the author's memory of all those individuals who have contributed. Therefore, the following list of acknowledgements is arranged in alphabetical order and does not represent the sequence of exploration nor the significance of the information. Moreover, the author apologizes for any contacts that have been inadvertently omitted.

I. Acknowledgements

1) International Sources

I. Blumberg, Executive Vice President, International Committee Against Mental Illness, U.S.A.; B. Brown, M.D., Smithsonian Fellow, Woodrow Wilson International Scholars, U.S.A.; O. Bjorgun, The Royal Ministry of Local Government and Labour, Norway; N. Cooper, Chief, Vocational Rehabilitation Section, Vocational Training Branch Training Department, International Labour Office, Switzerland; M.D. de Rios, Ph.D., National Institute of Mental Health, U.S.A.; B. Duncan, Director of Information, Rehabilitation International, U.S.A.; J. Garrett, Ph.D., World Rehabilitation Fund, U.S.A.; T. Harding, M.D., Medical Officer, Division of Mental Health, World Health Organization, Switzerland; E. Kosunen, Officer-in-Charge, Secretariat, International Year of Disabled Persons, Switzerland; M.M. McCavitt, Ed.D., Special Assistant, International Affairs, National Institute of Handicapped Research; Z. N'Kanza, Director and Deputy Assistant to the Secretary General, Humanitarian Affairs, United Nations, Austria; P. O'Kura, Assistant Director International Affairs, National Institute of Mental Health, U.S.A.; G. Soloyanis, Ph.D., Director of International Operations, Goodwill Industries of America, U.S.A.; University Centers for International Rehabilitation, Michigan State University, U.S.A.; D. Waugh, International Labour Organization, U.S.A.; D. Woods, World Rehabilitation Fund, U.S.A.

2) National (United States of America) sources

J. Appel, Information Specialist, National Rehabilitation Information Center, Washington, D.C.; M.E. Backman, Ph.D., Director of Vocational and Social Services Research, ICD, New York City; M. Eisenberg, Ph.D., Secretary, Division on Rehabilitation, American Psychological Association, Cleveland, Ohio; J.C. Folsom, M.D., Executive Director, ICD, New York City; J. Grimaldi, Ph.D., Director of Social Adjustment Services, ICD, New York City; R. Hunter, National Mental Health Association, Washington, D.C.; A McCuan, Staff Coordinator, Policy and Programs, National Institute of Mental Health, Rockville, Md.; R.A. Millstein, Staff Director of National Action Plan Project for the Chronically Mentally Ill, Alcohol, Drug Abuse, and Mental Health Administration, Rockville, Md.; H. Pardes, M.D., Director, National Institute of Mental Health, Rockville, Md.; L. Perlman, Ed.D., Consultant, Silver Spring, Md.; B. Posner, Executive Director, President's Committee on Employment of the Handicapped, Washington, D.C.; F. Reissman, Ph.D., Co-Director, National Self-Help Clearinghouse, New York City; I. Robinoff, Ph.D., Project Director of Research Utilization Laboratory, ICD, New York City; L. Robinson, Assistant Director for Legislation, National Mental Health Association, Washington, D.C.; B. Rosenberg, Director of Vocational Rehabilitation Services, ICD, New York City; J. Schmidt, Associate Director, Fountain House, New York City; E. Sutherland, Technical Information Specialist, National Clearinghouse for Mental Health Information, Rockville, Md.; R. Van Devere, National Mental Health Association, Washington, D.C.

3) Literature search (See References)

The extensive list does not represent many other suggested contacts. The search has been interesting and enlightening but often frustrating because the concept of rehabilitation for the mentally ill frequently was not part of the vocabulary and often not included in planning. Additionally, the information available was not always current and even the data obtained regarding the past five years was obsolescent because of socio-political changes. Yet the pieces of the large global jigsaw puzzle are now taking form in the remainder of this monograph. Out of the diversified and multitudinous resources, three sections are structured.

Part One: Introduction contains comments regarding the origination of the plan for information exchange. This explanation is followed by a description of the scope of the problem of mental illness and a discussion of terminology. This first section concludes with a framework for consideration of rehabilitation.

Part Two: Rehabilitation of the Mentally Ill: The State of the Art Internationally surveys the views of certain organizations and the practices of selected countries pertaining to mental health, mental illness and with particular focus on the expressions or omissions of remarks about rehabilitation. The selection of organizations and of countries was not based on preconceived criteria but rather depended on the availability of information as well as the time schedule. The significance of traditional medicine also is explored to illustrate the healer's impact in the developing countries and, in fact to some extent in the more developed countries.

Part Three: The Future for Rehabilitation of the Mentally Ill seeks directions for solutions—recognizing that problems and solutions must be designed in terms of each country's cultural, social, political and economic requirements as well as the psychosocially disabled person's individual needs. Included in this section are comments on the World Health Organization Credo—Health For All By The Year 2000 as well as description of the aims of the International Year for Disabled Persons in 1981. These commentaries are followed by reports on innovations in rehabilitative procedures and summary statements about the dimensions of rehabilitation for the mentally ill.

II. Scope of the Problem and Explanation of Terminology

Cultural and generation gaps, racism, apartheid, poverty, dehumanizing work and living conditions, urbanization, and the like are offered as a few of the world-wide psycho-social stresses that are causative factors in the dramatically increasing mental disorders, alcoholism and drug dependence, delinquency and violence. The waste in human resources is aggravated by the negative attitudes and patterns of the public—constricted by superstition and even more seriously hampered by prejudice and misinformation. These hobgoblins of misunderstanding provoke fear, become a barrier to potential solutions, and cloud the realization of the magnitude of the problems confronting people troubled by mental illness.

There are no accurate statistical findings on the global dimensions of mental illness. An overview gathered from sources indicates the following:

> *There are some 500 million "significantly" disabled people in the world, increasing at the rate of 3 million each year... About 300 million significantly disabled people can be found in less developed countries. Those "least disadvantaged" are to be found in small, often remote, villages, or in vast, squalid urban slums—nearly always without access to any services to help them overcome their disabilities.* (Acton, 1979)

> *Over 40 million persons of various ages suffer from serious mental illnesses (WHO, 1975) and the same is true of the over 200 million suffering from less severe mental disorders.* (World Health, 1977)

> *In the United States, approximately 800,000 people per day receive psychiatric care in state, federal, or private mental hospitals. (ILO Information, 1979) In other words, approximately one-quarter of the hospital beds are occupied by persons with emotional problems and each year admissions equal more than one-third of a million. In a recent year some 68 percent (approximately 3.5 million) persons received treatment in various types of out-patient centers.* (PCEH, 1977)

> *Every year about 5 million people in the United Kingdom confer with their family doctors about psychiatric problems. Some 600,000 are referred to psychiatric specialists. About 250,000 become in-patients.* (ILO Information, 1979)

A great deal of progress is evident in the re-integration of the physically handicapped but for psychiatric patients restoration to suitable social and economic life is bleak. This state of affairs is extremely grave. It is conservatively estimated that one person in ten of any society is likely to be incapacitated by a severe psychiatric disorder at some stage of his or her lifetime. Current estimates conjecture that the frequency of mental illness is a major disability interfering with the quality of life of numerous individuals. Future projections point to an even more alarming prediction that by the 21st century the total number of people with mental disorders will increase to 200 million. (ILO Information, 1979)

In spite of the gravity of the problem, these "unpersons" — the mentally ill—continue to be ostracized. Many are relegated to the institution or sent forth into the community unprepared for the rigor of living in an unacceptant community in a ghetto-like existence. Often the stigma of mental illness and the fear of detection prods the individuals and the family to conceal the problem and to avoid obtaining assistance for their disability. Thus these attitudes erect barriers to the effective utilization of even the available services. (Gaw, 1975; Kleinman, 1975) About half of the patients who are released from psychiatric hospitals return there within the year; and up to three-quarters of these patients use the revolving door back to the hospital within three to five years. (Anthony, 1980)

Inaction is rationalized on the basis of the world-wide economic slump, high unemployment, the shortage of funds, the many other pressing health problems, the scarcity of mental health professionals, and so forth. In developing countries the validity of these concerns cannot be denied. However, mental health care and particularly rehabilitation can serve as channels for increasing the productivity of individuals. Clear thinking about human rights and social justice brings mental health needs within the constellation of general health services. (WHO, 1975)

The grim description of the global problems associated with mental illness is changing—perhaps too slowly—but changing nevertheless.

> *In the last two decades there has been a major shift in the organization of health services all over the world. There have been efforts to "deprofessionalize" many health activities, to decentralize services and to place increasing emphasis on providing services for "priority problems" for everyone. This shift can be viewed as a "public health" or "community" approach as compared with the earlier emphasis on individual health care.* (Murthy, Dec., 1977)

The implication of Murthy's statement is that the health of the community—public health—is inseparable from the health of its residents. In another vein, this community approach recognizes the impact of intolerance of deviance. Such intolerance is apparent in all societies and interferes with the supportive climate essential to the social reintegration of the mentally ill. Research findings support the notion that the acceptance of differences in performance is a significant factor in maintaining lower functioning individuals in the community (*Freeman, 1976*). In those countries in which religious and magical conceptions of mental disorders prevail, traditional healers can perform an important service because of their acceptance and authority in the community (*WHO, 1975*). In such developing countries, effective and humane healers can prompt favorable attitudes toward the mentally ill person within the family and the community. In other situations, it is essential that carefully planned communication techniques are utilized so that the efficacy of rehabilitation of the mentally ill is brought to the attention of the general population as well as the policy-makers.

The discussions to this point actually only provide the infrastructure upon which meaningful planning for rehabilitative efforts may be constructed. Another item that requires clarification relates to the plethora of terms and the semantic confusion associated with the term mental illness.

The grab-bag term mental handicap is unsuitable since it connotes both mental illness and mental retardation. Thus the term obscures the difference between "illness" that is related to inappropriate behavior, difficulty in interpersonal relationships, inability to perform in the community in accordance with standards for the person's age and sex, and the like. These characteristics may also be demonstrated by the mentally retarded person but the origins of these similar characteristics stem from cognitive dysfunction—significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior manifested during the developmental period.* A mentally retarded person may be mentally ill but the two conditions are separate in causative factors, reality orientation, potential level of abstract thinking, and level of emotional expression and control. Mental disorder, psychiatric/mental illness or disability, and psycho-social disabilities all refer to the classifications as stated in the World Health Organization's *International Classification of Diseases* or in the (U.S.A.) American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders,* (DSM III, Third Edition, 1980). Because of the bewildering conglomeration of terms and meanings that continues to be used in various countries, some concerted action would be wise. Statistical accuracy, diagnostic clarification and treatment/rehabilitation procedures could be furthered by transcultural efforts directed to adoption of culturally acceptable terminology with definitions that are internationally appropriate and relevant. The World Health Organization has established the groundwork for these endeavors.

An even more crucial call to action emerges from the dilemma that ensues when the care of the mentally ill involves only custodial care. The psychiatric revolution that emanated from the introduction of neuropletic drugs resulted in dramatic progress in the late 50's and early 60's. Patients could be released from institutions after a short period of time and as long as they continued with their medication, were accepted by their families and the community; they could avoid re-institutionalization. But... this did not consider the fulfilling opportunity for the individual to reclaim a meaningful life including a rewarding participation in the community—to perform productive work that is self-satisfying and to be part of the social life of the community.

To be responsible and responsive does not necessarily signify complete recovery.

> *In some cases rehabilitation has more limited goals, e.g., enabling a patient to reach a state of being able to attend entirely or in part, to his own daily living. Even this degree of rehabilitation is of considerable economic value, quite apart from the humanitarian aspect.* (Rost, 1980)

In essence, therefore, it is inaccurate to assume that the control of symptoms—the removal of psychopathology—restores the individual to normal community functioning. In addition, it is fallible thinking to suppose that coping behaviors and functional skills learned in the hospital setting are transferable to community adaptations. Thoughtful, comprehensive and practical rehabilitative measures must be formulated so that the individual may develop the requisite competencies for community-living. Survival in the community depends on a multitude of factors rather than on the sole issue of psychopathology. (*Anthony, 1980*) It is rehabilitation that is often the missing link.

Rehabilitation is one phase in the continuum of comprehensive services required by mentally ill persons to re-establish themselves so that they may experience satisfying and satisfactory participation in their cultures. The process of rehabilitation requires the selection, blending, and use in appropriate sequence and relationships—for the individual's needs—of medical, psychiatric, educational, vocational, social and auxiliary therapeutic services. This constellation of services is aimed at minimizing the vigor and the influence of the mentally ill person's psycho-social disability.

The focus of this ongoing process is on the whole person—the holistic approach—which prescribes assessment of the total life needs and problems of the *whole* human being. This assessment of each person's capacities and limitations—strengths and weaknesses—serves as the baseline for programming individualized goals. The outcome of this programming is the restoration of the person to the fullest possible physical, psychological, intellectual, socio-recreational, vocational, economic, familial, and community usefulness of which he or she is capable. (Kline and Blumberg, 1974; Gandy, 1980) In this context, rehabilitation emphasizes a fluidity of movement from one type of service to another and differential levels and variety of client functioning. The consequence of this viewpoint is that individuals may be adequate within their cultures even though work would not be a viable or desirable outcome of the rehabilitative process.

Although the term rehabilitation is used throughout the discussion in this monograph, the concepts of habilitation and reablement deserve clarification.

> **Rehabilitation** in its nuclear meaning has been considered as the restitution of dignity and the restoration of the individual's previous level of functioning. (*Oberman, 1965*) In the broader holistic definition, rehabilitation is delineated in the previous paragraph.
>
> **Habilitation** stresses similar concepts of dignity but differs insofar as the reference is to training in skills that the individual had not accomplished previously. Therefore, the aim is for the establishment of new and necessary skills rather than the re-establishment of previously learned skills.

*Grossman, H., editor Manual on Terminology and Classification on Mental Retardation, Washington, D.C.: American Association on Mental Deficiency, Revised edition, 1977.

Reablement (Norton, 1978) is a term that has been used in reference to the elderly yet it has applicability in the substance of these remarks. Reablement indicates the achievement of a reasonable level of functioning within certain limitations as well as favorable specially arranged conditions of the environment. Coping skills are developed so that the individual may experience his or her maximum level of independence within a framework of suitable support systems. Reablement takes account of the fact that 'absolute cures' for many forms of psychiatric disorders are found more frequently in popular discourse than in real life. (*Kline and Blumberg, 1974*)

The common elements in the three terms just presented is that every mentally ill person has the right to reinstatement in a social niche within the community and whenever feasible also within his or her family. All of these terms are coherent with the holistic view that integrates three themes in the concept of rehabilitation, namely: the vocational or work-related theme, the medical theme, and the competence or community rehabilitation model. (*Grantham, 1980*)

The competence model actually incorporates both the vocational and medical themes and proposes the following: (*Adapted from Grantham, 1980 and Lamb, 1977*)

1. The environment is a significant aspect of the rehabilitative process. Therefore, individuals should be rehabilitated primarily in the community settings in which they are likely to reside and to work. Thus the loss in transfer of learning may be decreased.
2. Effective rehabilitation planning and procedures shapes the environment to ease individuals' achievement of their maximum psycho-social and vocational potentials as well as to become prepared to cope with their residual disabilities.
3. Individualized and culturally appropriate goals developed from a diagnostic planning process form the framework within which rehabilitation occurs. Goals must be defined and expectations clarified—for the person to be rehabilitated, for the professionals involved, and for other persons—staff, family, and so forth—who become part of the rehabilitation process.
4. The salient aim within the framework of the established goals is to assist individuals so that they may attain a sense of mastery of their internal needs, symptoms, and the demands of their environment. By these means, some degree of balance between self-control and environmental expectations may be accomplished.

Treatment and rehabilitation considered from the perspective of the competence model become mutually interactive processes—both are invoked at the earliest possible time. The arrangement for treatment-rehabilitation may be sequential, intermittent, or concurrent depending on the judgment of the practitioner regarding the needs of the person to be rehabilitated.

Dissimilarity between treatment and rehabilitation occurs as follows:

> *... in the specifics of the techniques employed and of the service systems which undergird the application of these techniques (and) more fundamentally, differences lie in the delineation of... short and long-term goals... Primary short-term goals of treatment are to 'normalize' bizarre or deviant thoughts, feelings or behavior, to diminish or eliminate excessive psychic stress or anxiety, to limit the severity and duration of psychopathologic symptoms. (The long-term goals associated with rehabilitation... involve techniques and processes specifically and systematically designed to enable a dysfunctional individual to attain the highest possible level of personal, social, and vocational functioning in the most normal and least restrictive environment.* (Kline and Blumberg, 1974)

The complexity of the person-environment system is the distinquishing feature of the preceding discussion of the competence model and the holistic approach. A Rehabilitation Spectrum* summarizes the six principal areas in the medical and mental health continuum of services. The Spectrum includes the following:

1. **Psychiatric Services** — crisis stabilization, symptom amelioration, medication management
2. **Family Services and Other Social Services** — back-up support (financial, counseling, respite care); for the client: income maintenance, financial management, counseling
3. **Community Services** — training for community living, community involvement and development activity, community education
4. **Educational Services** — increasing educational resources, filling in educational gaps, furthering educational opportunities as needed
5. **Vocational Services** — identifying work-interests and work-skill resources, work training including work habits, job opportunities, placement assistance
6. **Socio-recreational Services** — social and leisure skills developed, opportunities for day, evening and week-end activities

Each of the six components of the Spectrum contribute to the quality of life, but each component varies in significance for an

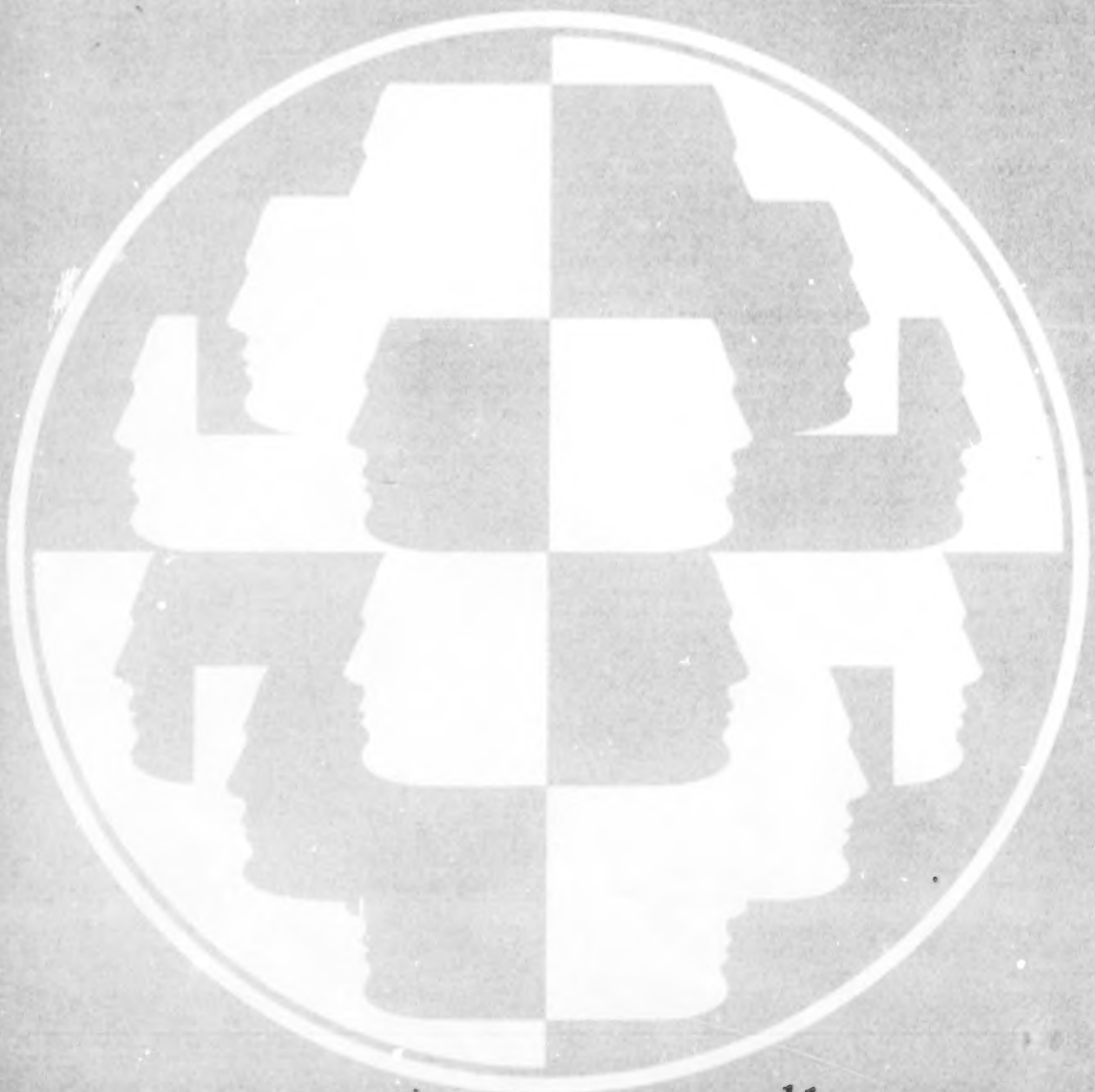
*Derived in part from: Greenblatt, M., The Rehabilitation Spectrum, In Greenblatt, M. and Simon, B., editors, Rehabilitation of the Mentally Ill, Washington, D.C.: American Association for Advancement of Science, 1959, 13-23.

individual. Thus the individual rehabilitation plan is an essential framework in order to establish goals and training activities in the case management process.

The transitional steps toward independence in living arrangements and self-care are another important consideration. All mentally restored people require some degree of assistance in this transition from a protected to an open environment requiring numerous decisions and a variety of interpersonal relations. Relocation from the institution to the community confronts the former patient with a new role, new expectations, and a discontinuity in atmosphere. This culture shock can be alleviated by means of carefully graded steps that avert the threat of too much responsibility as well as too much community. Programs in some countries decrease the intensity of these "shocks" by maintaining disabled persons in or near their community of origin, others begin with a simulated "community" within the hospital grounds (*Dencker, 1980*).

Much can be learned from an examination of other cultures. The paucity of attention to rehabilitation of the mentally ill is one similarity that may be gleaned from the survey presented in Part Two of this monograph. Public and often professional attitudes of fear, annoyance and even rejection very often are concealed but yet subtly disclosed in the priorities and consequent services for the mentally ill.

Part Two: Rehabilitation of the Mentally Ill: The State of the Art Internationally



I. The Law and Mental Illness

Three sources of information are included in the discussion of legislation in this section: the survey of legislation on the rehabilitation and employment of the disabled by the Council of Europe (1972-1977), the World Health Organization survey of law and mental health in 43 countries (*Curran and Harding, 1978*), and the United States Rehabilitation Act of 1973 as amended in 1978. The summary of these findings are arranged according to six divisions: Africa, Asia, Australia, Europe, North America, and South America.

Africa

Three of the ten countries surveyed by WHO during 1975-1977, updated their mental health laws in the 1970's.

Ghana in 1972 enacted the Mental Health Decree updating the 1888 Lunatic Asylums Ordinance.

Senegal in 1975 enacted legislation specific to the conditions of their country that also is in accordance with contemporary psychiatric principles and practice. The law provides for the establishment of "psychiatric villages" in each region. Mentally ill persons and their families live in these villages receiving psychiatric services as needed.

Sudan in 1975 enacted the Public Health Law providing treatment for the mentally ill as part of the general public health law. This law established Mental Health Boards in each Province mandating these Boards to determine the need for local Mental Health Boards and if needed, the Mental Health Board of the Province would be responsible for organizing the local Boards in the local executive Councils.

Ethiopia and Rwanda have no formal laws for mental health care; and Benin enacted the Law on Lunatics in 1838 but in practice has an informal system. Lesotho's Mental Health Law of 1963 is more recent than Nigeria's Lunacy Law of 1916, Egypt's Mental Health Act of 1944, and the United Republic of Tanzania's Mental Disease Ordinance of 1958. However, Lesotho's law follows the pattern of legislation in several developing countries, it has colonial origins based on the English-Welsh Act of 1959 rather than reflecting the particular cultural milieu and resources of Lesotho.

Asia

The majority of the 17 countries in the WHO survey (Curran and Harding, 1978) have no specific legislation covering treatment or hospitalization for mental disorders. Such an informal system exists in:

Bahrain
Iran
Iraq
Jordan
Kuwait
Qatar
Saudi Arabia
Thailand
Yeman Arab Republic

The most recent legislation enacted in three of the countries occurred in the 1950's, as follows:

Japan in 1950—The Mental Hygiene Law as amended
Malaysia in 1952—The Mental Disorders Ordinance
Syrian Arab Republic—1954 and 1965 Decrees, Regulations and Instructions

The remaining countries have legislation from the 1930's or from 1912.

Cyprus in 1931—The Mental Patients Law
Democratic Yemen in 1938—The Lunacy Ordinance

The Lunacy Act of 1912 is applied in *Burma, India* and *Pakistan*. The Act originally introduced by the British Colonial authorities does not satisfy psychiatric service objectives and is not in accordance with contemporary public health aims. In India the 1912 law relates to the entire country but the administration of mental health services is the responsibility of each of the states. Specific proceedings, assignment of places for institutionalization, regulations for care for treatment and for licensing, and certain aspects of the care of psychotic criminals—all may be legislated in India by the state in accordance with Section 91 of the Lunacy Act. Revisions have been considered but have not as yet been implemented.

Australia, Fiji

The Commonwealth Government of Australia has announced the establishment of a Human Rights Commission that will undertake research concerning human rights. This Commission will advise the Government about the means for the protection of these rights and will arrange for continuing evaluation of human rights legislation as well as act as a central coordinating point for complaints of discrimination.*

According to the WHO survey (*Curran and Harding*, 1978), the following Acts have been enacted.

South Australia in 1935— The Mental Health Act (with revisions to 1974)
as of 1979— The South Australian Committee on Rights of Persons with Handicaps plans to examine laws and policies affecting persons with mental handicaps.*
Victoria in 1959— The Mental Health Act
Fiji in 1940— The Mental Treatment Ordinance, amended by the Mental Treatment (Amendment) Ordinance of 1964
in 1967— The Mental Treatment Ordinance

Europe

The countries included in the Council of Europe support the contention that rehabilitation is no longer a favor. Instead, it is the:

*Commonwealth Attorney-General's Department, Prevention through law, (Australian) National Rehabilitation Digest, 3(2), 1979, 24-28

. . .right of every physically and mentally handicapped person to all measures—medical, educational, vocational and social for the purpose of achieving the fullest possible reintegration in society. . . Rehabilitation is a continuous process beginning with the occurrence of the illness or accident and lasting until the time (the person achieves) the best possible living and working conditions. The active and continuing cooperation of the disabled person himself plays an essential part. It is of prime importance to combine as early as possible the curative with the functional and occupational stages of rehabilitation.

The Council adds its concern to the World Health Organization and other organizations stressing the magnitude of the problem of rehabilitation needs. The ever-increasing number of disabled people urge a scientific approach coupled with long-term planning. The Council's goals and directions for achieving the goals propose a hard look at the legislation in Europe and the outcome of this observation is not too favorable particularly for the psycho-socially disabled.

Specific and well-defined mention of rehabilitation services for the mentally ill is contained in the *United Kingdom's* Mental Health Act of 1959. Similar Acts were legislated by *Scotland* in 1960 and by *Northern Ireland* in 1961. These Acts were innovative in their approach to services. Emphasis was placed on the development of community-based supportive services for the mentally ill; and rehabilitation was mandated to be integrated within the total treatment process commencing when the first contact for psychiatric services was made. Limited occupational facilities usually are provided in the bed areas and extensive occupational, social and recreational facilities are available in separate buildings on the grounds of the mental hospitals. The 1959 Act also required that new psychiatric departments should be established in day hospitals.

Day centers administered by local authorities aim to continue the process of rehabilitiation when the patient no longer needs hospital treatment, but may not be ready to accept open employment or the rehabilitation services under the auspices of the Department of Employment.

The final stage of rehabilitation prior to entry into vocational training or employment may take place in the Industrial Rehabilitation Units. . . .close cooperation between disablement resettlement officers of the Department and those responsible for rehabilitation in the hospitals and local authority Social Science Departments, to ensure that mentally disordered patients are referred to a unit only when they need and are ready for such a course in order to progress to employment or training.

For those people who have been in a psychiatric hospital for a long period of time, work requirements may have to be easier-paced and in a less sophisticated environment. The Industrial Rehabilitation Units (IRU's) administered by the Department of Employment and Industrial Therapy Organizations serve as training sites for these individuals who must tackle the work-world more gradually.

Three other countries identify rehabilitation with psychiatric needs, namely Belgium, The Federal Republic of Germany, and The Netherlands.

Belgium (Council of Europe, 1972-1977)

Belgium has had a steady broadening of the rehabilitation concept in the field of public health, especially relating to the psychiatric and occupational re-education of disabled persons with very little residual skills. The Law of 1956 established the Special Aid Fund to contribute to the maintenance, treatment and educational costs for the indigent insane, deaf-mutes, blind, disabled by incurable infirmity, tuberculosis or cancer sufferers. This Fund is to be allotted to the listed disabled people when they are placed in institutions or other establishments recognized by the Ministry of Health.

By implication the 1963 Act refers to the mentally ill since it provides for the reintegration into society of all disabled persons, without distinction. This Act is the source for the new attitude which the community is urged to adopt towards the disabled persons. Humane, social and economic solutions that go beyond the practical aid derived from pensions is the credo to be upheld. A public institution was created to deal with the resettlement of disabled persons FNRSH (Fond National de Reclassement Social des Handicapes).

The Federal Republic of Germany

The 1961 Act (revised in 1969) extended the scope of the 1953 Act so that assistance might be offered to the blind, to persons with hearing or speech defects and to mentally and psychologically handicapped persons. This aid is directed towards social integration so that the disabled person may become part of community life. Preparation for employment and preferential employment is part of the directives of the law. The Frankfurt Agreement further affirms the employment and career rights of the disabled persons. Rehabilitation establishments have joined with the Federal Working Party to mutually act in the promotion of work opportunities for the disabled.

The Netherlands (Council of Europe, 1972-1977)

The General Special Sickness Insurance Act of 1967 provides funds for the long-term care in hospitals and other intramural institutions for the physically, sensorially, and mentally handicapped. These funds are not available for the first year spent in a hospital, TB sanitorium or psychiatric hospital but may be obtained after this period which is usually covered by private insurance. The purpose of this Act is to provide benefits and measures for medical treatment and other care that are designed to motivate, re-establish or improve the capacity to work or to improve living conditions.

The countries with legislation referring to the mentally handicapped are not included in the three countries listed above since the broader term usually either encompasses both the psycho-socially and the mentally retarded disabled persons or solely identifies the mentally retarded persons for rehabilitation procedures. *Italy* may be referring to either of these categories—mentally ill and/or mentally retarded in its act of 1971 that extended assistance to all categories of physically and mentally handicapped people except victims of war, industrial accidents, or occupational diseases as well as deaf mutes and the blind for whom existing laws would continue. The fundamental change in the law is the extension of state pension assistance to all disabled persons regardless of their means. Added to this is the allocation of occupational training, sheltered employment and an improved social life so that total integration may be achieved.

Priority consideration for employment, quotas, compulsory percentages are stated in the legislation of the following countries in the Council of Europe survey.

Austria: The Placing of Invalids Act obliges all employers to a certain percentage of jobs for handicapped persons whose earning capacity is reduced by at least 50%. Employers who do not fulfill their obligation have to pay a so-called compensatory tax that is used to finance the welfare activities for disabled persons. In 1969, the Federal Act on Labour Market Promotion provided job redesigning aids at public expense.

The Federal Republic of Germany: The 1953 Act with revisions in 1961 and 1969, established quotas for the employment of disabled persons. This preferential job-placement must be such that the disabled persons would use their existing abilities to the full extent and also would have further opportunity to develop their abilities and knowledge so that they might advance in their performance.

France: The Act of 1924 with later Decrees in 1965 and 1971 established quota systems for the compulsory employment of, at first, only the war disabled and later other disabled persons. This priority employment was to be practiced in both the private and public sectors of employment.

The Work Centers, similar to sheltered workshops in other countries, provide jobs for persons with a reduced work capacity or those who require permanent medical, social and psychological assistance.

Italy: The Act of 1968 mandates the employment in the public and private sectors of all categories of disabled persons and fixes the proportions of jobs to be reserved in each category. (There is no specific mention of the mentally ill in the list of disabled persons for compulsory employment policies).

The Netherlands: In 1947 the Disabled Persons Employment Act established a compulsory percentage of disabled persons to be employed by public and private firms. However, this Act is no longer of any practical significance since business firms and industries voluntarily employ a sufficient number of disabled persons.

An even more important Act is that of The Supplementary Employment Schemes Act of 1967 which is actually a Rehabilitation Act and is usually referred to as the Social Employment Act. The innovative aspect of this Act is that it has introduced the development of forms of adapted work for the unemployed having difficulty in finding another job and also various forms of productive work for people unable to be placed in open employment for different personal reasons.

The United Kingdom: The Disabled Persons (Employment) Acts of 1944 and 1958 required the appointment of resettlement officers for the disabled persons guidance and assistance in job placement. These officers are located in the local offices of the Department of Employment. Under these Acts many employers are obliged to employ a quota of disabled persons.

The legislation that more frequently refers to hospitalization procedures, definitions of "mental handicaps," mental health procedure, and criteria for voluntary and or involuntary admission to institutions were the primary focus of the WHO survey. (*Curran and Harding, 1978*) The following discussion lists some of the findings.

The most recent mental health legislation in Denmark, Norway, Poland, and Basel Stadt, Switzerland is dated in the 1950's or 1960's, as follows:

Denmark:
1938— Hospitalization of mentally ill persons
1959— Treatment of persons suffering from mental disorders and also comments about psychiatric departments

Norway:
1961— Psychiatric Care

Poland:
1952— Instruction by the Ministry of Health

Basel Stadt, Switzerland:
1961— Hospitalization of mentally ill persons

The remainder of the countries have updated their mental health legislation through the 1970's, as follows:

France:
1838— Relating to lunatics
1944— Establishment of a plan for a "colonie familiale"—a special center for locating former patients in foster homes in the community.
1955— Decree establishing central government funding on a sliding scale up to 80% for community mental hygiene clinics.
1960— Circular with master plan to operate hospitals on a "sectorization basis"—arranging patients by sectors of the departments in France to accomplish coordination of hospital and follow-up services.
1960— Regulations within the social security system support mental health treatment services in community centers. A Ministerial Circular issued the requirement that Mental Health Centres should be established in every city of over 20,000 residents.
1971— Control of mental diseases and the development of a health chart in the psychiatric field.
1972— Regulations of the departments for the control of mental diseases, alcoholism, and drug dependence.

Romania:
1958— Decree; and an Ordinance of the Ministry of Health
1965— Medical care of dangerous mental patients Ordinances of the Ministry of Health in 1972 and in 1973

Geneva, Switzerland:

1936— Provisions governing persons suffering from mental disease
(Adaptations in the later years of the 60's)
Legislation at the central government level with intercantonal agreements and an association of the cantons for certain health matters, for instance, the control of pharmaceuticals. Cantons are responsible for mental health services and the federal social insurance system has stimulated program development in some services such as rehabilitation and outpatient mental health services.

1971— Amended Penal Code—authorizes the use of cantonal mental hospitals and other services for the treatment and rehabilitation of drug-dependent persons convicted of federal crimes, of alcoholics and of the mentally ill.

Union of Soviet Socialist Republic:

1970's— Extensive legislation regarding guardianship and foster care placement as part of the process of patient aftercare in the community. Guardianship laws serve to facilitate earlier discharge maintaining former patients in the community.

United Kingdom (England and Wales):

1890— The Lunacy Act
1930— The Mental Treatment Act
1959— The Mental Health Act

Supporting the 1959 Act and revising or adding to the services are:

The Disabled Persons (Employment) Act of 1944 as amended by the Act of 1958
The National Health Services Acts 1946-1973
Health Services and Public Health Act of 1968
The Chronically Sick and Disabled Persons Act of 1970
Employment and Training Act of 1973
Social Security Act of 1975
The Supplementary Benefits Act of 1976

Scotland and Northern Ireland have enacted similar laws usually a year or two after England and Wales.

North America

The most recent legislation was dated in the 1970's in the countries included in the WHO survey of North America. (Curran and Harding, 1978) The following description is based on the WHO survey with additional information from the 1978 amendments to the United States Rehabilitation Act of 1973.

Alberta, Canada:

1972— The Mental Health Act

British Columbia:

1973— The Mental Health Act—Originally passed in 1964 and amended in 1968

Costa Rica:

1973— The General Health Law contains a number of provisions encouraging the development of mental health services on a voluntary basis.

Trinidad and Tobago:

1975— The Mental Health Act contains innovative provisions for personnel and also new appeal provisions for the protection of patients' rights.

United States of America:

1963— The Mental Retardation Facilities and Community Health Centers Construction Act. Community mental health services are operated locally and usually are responsible for prescribed catchment areas. Citizen's Advisory Committees (or Boards) consist of appointed members who become knowledgeable about the center's services and seek to represent the community's needs for health services. The functions of the members vary in different localities but, in general, they serve as advisors to the administrators of the centers and often as advocates for service needs. The community mental health centers are administered by country governments and are partially funded by grants from the federal government with additional state funding. These mental health center are designed to provide comprehensive services among which are outpatient, emergency and consultation-education.

The Rehabilitation Act of 1973 is particularly germane to the discussion of services for the mentally ill, particularly because of the amendments of 1978. Excerpts from this Act were quoted at the beginning of this monograph to present the importance that the United States ascribes to information exchange at the national and international levels. Within the present context, the items pertinent to rehabilitation of the mentally ill will be presented.

One of these items refers to grants and contracts allotted to states. Funds are appropriated specifically for projects:

Sec. 304(a)— to assist in increasing the numbers of personnel trained in providing *vocational, medical, social psychological rehabilitation* services.

The addition of the specified services enriches the extensiveness of the services to be made available. Furthermore, recognition of the special needs of the mentally ill is expressed in the addition of *rehabilitation psychiatry* to the types of personnel to be trained. Thus the *specialized personnel providing job development and job placement services for handicapped individuals would be expanded*. Sec. 304(b)

Three major issues concerning services for the disabled have been pursued with some regularity in the United States. These issues are as follows:

1. to increase the number of severely disabled persons who receive services,
2. to establish comprehensive services, and
3. to support activities associated with independent living.

The resolution of these issues entails a change in attitude toward the civil and benefit rights of disabled persons. The enactment of Public Law 93-112—The Rehabilitation Act of 1973 and of Public Law 95-602—the 1978 Rehabilitation, Comprehensive Services, and Developmental Disabilities Amendments have set forth the legal mandates to provide and protect these rights. (*Jarvis, et al, 1979*)

PL 93-112 did mandate priority rehabilitation services to the severely disabled, yet the primary objective of service provision continued to be "competitive gainful employment." Non-vocational objectives such as independent living services were not included. However, the passage of PL 95-602 finally legitimizes "independent living services" and "non-vocational goals" as viable alternatives:

> *The purpose of this Act is to develop and implement through research, training, services, and the guarantee of equal opportunity, comprehensive and coordinated programs of vocational rehabilitation and independent living.* (Section 2)

Moreover, comprehensive services are clarified and grants are to be made available for the establishment of comprehensive rehabilitation centers to:

> *. . .provide a broad range of services to handicapped individuals, including information and referral services, counseling services, and job placement, health, educational, social and recreational services, as well as to provide facilities for recreational activities.* Title III. Sec. 305(a)(1)

Provisions for independent living are the crucial breakthrough mandated in PL 95-602.

> *Title VII, Sec. 702(b)—Comprehensive services for independent living means any appropriate vocational rehabilitation service—and any other service that will enhance the ability of a handicapped individual to live independently and function within his family and community, and if appropriate, secure and maintain appropriate employment.*

The trend toward more comprehensive services is obvious. Mandated services for the more severely disabled including psychiatric disorders are explicit. The legitimation of non-vocational objectives is well-defined. And, yet, barriers to the implementation of these mandates impede the full realization of the provisions of PL 95-602. Three predominant factors critically affect service provisions in the resolution of the disabled person's needs. These are as follows: (*Jarvis, et al, 1979*)

1. *. . . ideological differences that induce dissimilarity in the interpretation of key words in the legislation. The meaning of "severely disabled," of "comprehensive services," and of activities associated with "independent living" might vary in the scope of their definitions.*
2. *. . . an approach to the delivery of vocational rehabilitation services that emphasizes "success with client" in quantitative terms. Thus the measure of success becomes—the number of clients served—the cases closed. The vocational goal of a minimum accomplishment of two months employment is the concentration of this quantitative score. The quality of services suffers with such measures of success; the more complicated, problematic disabled clients are less likely to be tackled when speed of solution and immediacy of job-placement are criteria of success. Basically the issue becomes efficiency versus equity.*

To be effective, the objectives of the state vocational programs must accept non-vocational outcomes as viable measures of success.

3. *. . . the inadequacy of federal funding commensurate with the state's budgetary requirements for expanding services and/or establishing new services. Indubitably legislation performs a pivotal role in the determination of policies and procedures at various governmental levels. Funding, however, often depends on other priorities that do not always coincide with federal fiats.*

South America

The major mental health legislation in three South American countries is reported in the WHO survey. (*Curran and Harding, 1978*) These are as follows:

Brazil:
1934— Provisions for the care and protection of the person and possessions of mentally ill persons. Amended in 1961 and in 1974

Peru:
1952— Executive Decree—prescribed regulations regarding mental health
1963— Supreme Resolution—amended certain Chapters in the mental health regulations

Uruguay:
1936— Mental health legislation

The survey of legislation reveals a trend toward changes in treatment methods and to some extent in public attitudes towards the mentally ill beginning with the 1950's. Significant revisions occurred in mental health legislation after 1950 with shorter hospitalization and a growing awareness of the complexity of psycho-social needs for rehabilitation as these relate to the mental health delivery system. Specifically designed legislation concentrating on the rehabilitation of the mentally ill is evident in only a small percentage of the countries surveyed.

The many legal reforms that occurred in several countries at the end of the 1950's and in the early 1960's have waned in the 1970's. In the developing countries, the pattern of existing laws indicates: (*Curran and Harding, 1978*)

- Many operate under informal systems in regard to hospitalization and treatment services.
- Others function under statutes of colonial origin adapted from the domestic laws of the former colonial power. These laws are many decades old, long since repealed in the home country, and probably never were applicable to conditions in the developing countries.
- In a small number of the recently established independent nations, new legislation has been enacted that is particularly applicable to the cultural and mental health needs and resources of the country.

Fifteen of the countries surveyed expressed general satisfaction with their existing laws. Even some of the twelve countries with informal systems regulating mental health services communicated similar comments. Often, the social norms supported the informal system since traditions delegated to the family the responsibility for the care of their relatives, in concert with healers and/or psychiatric efforts.

Some of the legislation presented in the survey has been the source of innovative procedures, for example:

- a trend toward voluntariness in mental health care as demonstrated in the community-based centers as well as in voluntary admissions for in-patient care. One of the most notable changes in the delivery of mental health services since the 1950's has been the increase in community-based programs and facilities.
- an emphasis on comprehensiveness in the mental health programs. Thus the alternative that is least restrictive to the personal freedom status and privileges in the community may realistically be applied in planning for each individual.
- the emerging use of health auxiliaries with shortened, simplified and practical training. These paraprofessionals work alongside the professional mental health workers and sometimes must assume responsibility in some of the areas in which psychiatrists or mental health workers rarely or never visit.
- family-oriented programs have sprung up particularly in some of the African villages. In these villages the family as well as the patients are afforded psychiatric and other services and the family becomes part of the psychiatric team.
- the advance in the concerted efforts to study human rights issues concerning the mentally ill in order to legally confirm these rights and to arrange for advocates to support and assist in the implementation of these rights.

Gaps in mental health legislation and also in the implementation of existing legislation are apparent in both the developed as well as the developing countries. There is a need to decentralize (perhaps to regionalize) the system of services thus reducing the reliance on large central mental hospitals. Secondly, mental health services would receive more favorable stature if integrated as the right of the individual as part of the general health services. When differentiated from health needs, these services demand psychiatric interventions and discourage the expertise that can be developed in the "new mental health workers" who can be trained as generalists. Thirdly, legislation must be "sensitively framed" for those areas in which traditional healers of various kinds can perform a socially valuable function, "all the more since their patients may have difficulty in receiving modern medical treatment of any kind." (*Curran and Harding, 1978*)

Finally, specific legislation should spell out the framework for rehabilitation of the mentally ill and should legitimize planning and programs in this area.*

*See Curran and Harding, 1978 and Harding and Curran, 1978 for additional guidelines proposing a "basic statutory structure."

II. Transcultural Survey of Rehabilitation Procedures for the Mentally Ill

Transcultural technical cooperation can be useful to both the labor-rich, capital-intensive, urban-oriented countries as well as those countries who are developing in a multitude of directions. Both humanitarian and cost-benefit rationale urge such transcultural communication.

For the foregoing reasons as well as the upsurging incidence of mental disorders in both developed and developing countries, a call to action has cogency.

The transcultural survey that follows present some items of interest pertinent to the delivery of mental health services. The countries are organized in accordance with the same six divisions arranged in the previous discussion of Law and Mental Illness.

Africa

Africa, the second largest continent, situated in the Eastern Hemisphere, is characterized by the grafting of foreign cultures on its older cultural ways. This acculturation process is particularly noticeable in urban areas. (Diop, 1973) Despite the acquisition of other culture and the people's general receptivity to modernization, there are tenacious examples of the perserverance of traditional mores. The social organization, for instance, is still founded on the extended family structure. However, urbanization and industrialization have introduced a dislocation of the traditional family structure and the trend toward the nuclear family. High fertility and high mortality exist plus the potential for population explosion since health activities have reduced mortality rates. The pluralism of the large population of Africa in itself exacerbates problems of the provision of mental health services.

In some of the African countries the insufficiency or complete lack of therapeutic facilities and therapists are the primary

deterrents to people seeking care. This shortfall results in the warehousing of patients in overcrowded institutions at a distance from their home when their behavior becomes sufficiently provocative within their community. In addition to the frequent custodial and palliative practices, the communication gap between the foreign-trained psychiatric personnel is a potent barrier between the psychiatrist and the patient.

Because of the scarcity of personnel and services, particularly for the larger majority of Africans living in the villages, the major burden of mental health practices often is handled by traditional healers; and for numerous other cultural reasons psychotic patients rarely seek help from modern health services even when these are available. (*Harding, et al, 1979*)

Though almost two decades in existence, the primary innovative procedures continue to be the therapeutic villages usually linked to the mental hospitals. This model was pioneered by Lambo (1961) who emphasized that a patient could bypass admission to any formal institution such as a hospital by living and receiving treatment in these villages. The staff of these villages is multidisciplinary and collaboration is encouraged with the mental hospital. Thirty to one hundred patients including their families live in these villages and participate in community activities. Communication between patient, family and the psychiatric staff is eased and thus social reintegration is facilitated.

These villages have been continued in modified forms in Nigeria, Senegal and Tanzania. Although some of the practices of these villages have been challenged, the contributions of the therapeutic villages issue from the incorporation of the family as part of the mental health team as well as from the village's recognition of socio-cultural structures that tap traditional methods of caring for the mentally ill (*Corin and Murphy, 1979*) and recognize that community involvement in mental health care is an indispensable factor. (*Harding, et al, 1979*) Moreover, these villages are particularly practical since their cost is much lower than hospitalization.

Healers' villages are another type of village existing in nearly all countries of Africa. These are usually traditional villages in which the treatment method might be marabout*, animist*, or syncretic* religion. Villages are headed by the healer who maintains an impressive role with the village population.

> *Cooperation between modern therapists and these healers would decrease the dangers from treatment of mental disorders of organic origin by means of the healer's methods which might be inappropriate. Besides, such collaborative efforts would facilitate the identification of the healer's techniques as well as advance the assessment of their skills and restrain the counterproductive influence of the unscrupulous healer.* (Diop, 1973)

The remainder of the discussion about Africa considers the treatment/rehabilitation services for the mentally ill in several countries of Africa.

The Arab Republic of Egypt (ARE) is the largest Islamic nation in the Middle East. The majority (90%) of the Egyptian people are Moslems of the orthodox Sunni sect. The Copts, descendants of the Seventh Century Egyptians, are one of the several Christian religious minorities; and a few inhabitants practice the religion of Judaism. (*Furnia, 1975*) As in other countries, the variety in religious and other socio-cultural and economic characteristics are significant in relation to attitudes toward and practices related to health.

Perhaps for all or most of the foregoing reasons GOARE (Government of the Arab Republic of Egypt) places mental health in a relatively low place on the Ministry of Health priority. (*Furnia, 1975*) Rehabilitative services are a part of social services within the responsibility of the Ministry of Social Affairs. The program includes medical, psychological and social services besides vocational guidance. In addition, there are residential living arrangements for the disabled in need of continuous care, sheltered workshops and cooperative schemes for the disabled. Problems of financial support for the increasing number of disabled persons and the lack of employment opportunities require attention. (*El Moomen, 1978*)

Benin has established psychiatric departments in some of its general hospitals. In Benin City, for instance, such a department was incorporated in the general hospital within ten kilometers of a mental health hospital. This led to at least two favorable outcomes. Patients were not placed in a large isolated hospital usually at a distance from their home community; and the diagnosis of physical disease preceded that of psychiatric disorder. Thus the stigma of mental illness often was avoided. Only when the patients symptoms persisted in spite of traditional or general hospital treatment were they referred to psychiatrists or psychiatric hospitals. (*Azing, Undated*)

The United Republic of Cameroon has given a new orientation to the policy of assistance. The major objective of this policy is to provide the disabled with the necessary training for learning a trade so that they might achieve economic autonomy and social integration rather than be dependent on temporary assistance and financial benefits. This has been entitled a policy of rehabilitation and the Ministry of Social Affairs is in charge of the implementation and administration of this policy at the national level. The Government is aware that the focus of the existing services is on physically and sensorially disabled individuals. Future efforts will be directed to revision of the outdated, insufficient legislation that is concerned with limited categories of the disabled and that concentrates only on medical care and material assistance without attention to the most important aspect of the problem. This aspect takes account of rehabilitation so that all citizens may achieve socio-economic integration and social justice. (*Fotchine and Nnama, 1978*)

Ethiopia is a country that combines efforts toward the incorporation of more modern techniques with traditional practices. Rehabilitation services are provided for the severely disabled with the technical assistance of the International Labour Organization. Three factories, currently self-supporting, employ 400 severely disabled workers. (*Burress and Perlman, 1979*)

On the other hand, there are the traditional approaches. For instance, the Zar cult is practiced in Gondar and the northwest Amhar region. This cult parallels a therapeutic community in

Marabout—a Moslem hermit or holy man who can attain states of ecstacy during which the secrets of the intangible world are revealed to him and he controls the forces of nature. *Animist*—belief in existence of spirits and demons that may be exorcised by certain healers. *Syncretic religion*—combination or reconciliation of differing beliefs or practices in religion, philosophy, etc.

which persons with psychic, neurological, and gynecological disorders continue to be involved even after relief from their period of acute suffering. Thus the cult is comprised of current and former sufferers of a variety of ailments forming a peer-oriented therapeutic mileu. Almond (1974) describes this group experience as "communitas" an essential ingredient that is supportive in the social integration of the "restored" individual.

The Zar cult differs from some other native healers that employ a dyadic relationship rather than the group process. "Wogesha" using herb-healing, has intimate knowledge and contacts with his patients. In some ways he is similar to the country doctor who practices general medicine in rural America. The "dabtara" is a religious scribe in the Copic church who considers his healing practice as secondary even though it is probably his major source of income. Other healers are involved with evil-eye sickness. ("buda") (*Almond, 1974*) The complexity of the social-medical practices including the categorization of diseases makes for interesting cultural studies but also complicates the establishment of therapeutic/rehabilitative measures.

Gambia has less than 750,000 inhabitants but at least six different tribes are represented in this population. These tribes have different traditions and languages and thus each requires slight variations in approach. Medical care has been available to the residents of urban and periurban localities (less than 20% of the population of Gambia); and the emphasis has been on the curative aspect.

In order to establish a primary health care (PHC) program for over 80% of the country, radical plans must include training personnel and localizing care systems. Community committees were formed, chaired by the traditional chief or his representative. This Committee selected Community Health Workers from its own village to be trained under the auspices of the Ministry of Health. This layered approach to an organization—intersectorial committees—permitted input from the village, the district, the interministerial and the National Planning Committee presided over by President Jawara. There is to be an intensification of the development of these Community Health Workers since overseas training has been expensive and not always relevant. (*Samba, 1979*)

Ghana appointed a committee immediately after Ghanaian independence to investigate the problems of disabled persons in the country. As a result of their findings, which concentrated on physical disabilities and blindness, a special section was recommended to be based within the Department of Social Welfare and Community Development. The aim for this section is to take the necessary steps so that each disabled person might attain social and economic independence with the goal of self-reliance.

There have been no concerted efforts to plan for the mentally disabled for whom there are three psychiatric hospitals in which schizophrenia is the most prevalent type of mental illness. The only form of rehabilitation for the psychiatrically disabled is hospital-based occupational therapy. Community rehabilitation does not exist for this group of disabled persons.

The Mental Health Association is one of the voluntary organizations that performs a useful role in the strivings toward the establishment of rehabilitation for the mentally disabled persons.

Ghana's efforts have been productive in rehabilitation programs for the physically disabled and the blind. With a low amount of fiscal resources the government has established a well-organized program within the framework of health and community development. Private groups and other agencies have contributed to this effort. (*Anim, 1978*) From all indication the framework for instituting rehabilitation procedures in the community for the mentally disabled already exists.

Kenya appointed a committee chaired by the Minister of Labour and Social Services. This committee, established one year after Kenya achieved independence, was directed to collect certain demographic data and to investigate existing services for the disabled as well as coordination procedures. Based on these explorations the committee was to formulate a broad program of training and placement involving community care for the disabled with the goal of economic independence for as many disabled persons as possible.

Some of the outcomes of the recommendations from the committee were: the origination of a National Rehabilitation Committee to coordinate services for the physically disabled and the mentally retarded individuals and also a division within the Department of Social Services. This unit is headed by a Senior Rehabilitation Officer with a centralized administrative control and is responsible for the program of care and rehabilitation of the disabled persons. With the assistance of ILO advisors this division has started a number of vocational rehabilitation centers both in rural and urban areas. (*Ligabo and Maniuda, 1978*)

Innovations in training have been attempted in Nairobi. Parents who have been trained in physical therapy techniques so that they can become part of the rehabilitation team in clinics; and other parents of mentally retarded children have been trained in methods for developing their children in their home-setting. In addition, an innovative approach to job opportunities and job training has been used with paraplegics who are trained in fishing and fly-tying by skilled non-disabled employees in a small shop. (*Burress and Perlman, 1979*)

The Government of Kenya has recognized that more suitably trained personnel are needed for the care and rehabilitation of disabled persons and has plans to create paramedical education and a vocational training center. Future undertakings include expansion of existing facilities to handle more clients, an increase in the number of institutions particularly in the rural areas, the formation of cooperatives for the disabled workers, and the encouragement of light industries in urban areas. (*Ligabo and Mahiuda, 1978*)

Liberia, the oldest independent African nation, has aided in the development of rehabilitation programs by several international organizations. Additional technical assistance is essential in order to continue to design, organize and implement a comprehensive proposal for rehabilitation services administered by a Deputy Minister. The President of Liberia has supported organizational efforts to establish national rehabilitation programs. Monravia (in Liberia) has a modern and well-equipped facility—The John F. Kennedy Memorial Center. However, the medical staff, especially the surgeons, consider this Physical Medicine and Rehabilitation (PMR) unit a luxury exercise facility scarcely using it as part of the rehabilitation process. (*Burress and Perlman, 1979*)

Libya, as of 1976, has established a department specializing in the mental health field, and for the purpose of supervising hospitals, sanatoriums, and health resorts providing health care to psychological, mentally ill and mentally retarded persons. At this time (1976), the Ministry of Health was preparing a plan specifically directed to the needs of the mentally ill and the mentally retarded to include: diagnostic and evaluation units, community-based services (out-patient services in general hospitals, a day hospital system), the training of specialized personnel, research (local studies to pinpoint causative factors in mental illness and mental retardation), and public education.

The day hospital system was to be formulated so that patients might obtain medical, psychological, social and vocational care as well as recreation during the day-time and return home to their family in the evening. Public education would utilize a variety of media to inform about the treatment methods in the day hospital and other programs. Incorporated in this education would be efforts to assist people to become aware of the implications of human relationships with workers.

Mauritius's government, in conjunction with voluntary organizations, have established welfare services, special schools and provocational programs for disabled young persons. The blind, the deaf, and the mentally and physically disabled have been the groups for whom these services have been implemented. It is only recently that vocational rehabilitation has become a national concern in Mauritius. The Mauritius Mental Health Association administers the National School for Educationally Sub-Normal Children whose ages range from 3½ to 22 years of age. Most of these students are classified as mentally retarded or slow learners and the remainder are disabled orthopedically or neurologically.

Plans for the future have under consideration items such as: staff training adapted to the needs of Mauritius and the particular types of disabilities, legislation to protect the rights of the mentally and physically handicapped, methods for casefinding and assessment to aid in prevention and planning, and a pilot scheme for a Vocational Rehabilitation Centre and a workshop conceived by the National Council for the Rehabilitation of the Handicapped. (*Latimer and Piat, 1978*)

Nigeria organized a National Council for the Rehabilitation of the Disabled in 1976 to advise the federal government about rehabilitation matters and to explore methods of integrating disabled persons into society. Rehabilitation centers for disabled persons have been established in six states of the Federation and eventually will exist in each of the 19 states. These centers provide vocational training, and sheltered employment and thus supplement the efforts of voluntary organizations. Multipurpose cooperatives have been recognized as one of the effective means of solving the nation's social and economic problems. Although there are no special cooperatives for the handicapped, many handicapped persons are members of existing cooperatives and are fully integrated into the society.

The success of these plans is complicated by the attitudes of the Nigerian population. Ethnicity and low educational level are just two of the factors impacting on the degree of progress the population accepts. (*Mach and Tuson-Imade, Undated*) Religious practices often deter the training of street side beggars, many of whom are disabled. Employers reject the idea that trained disabled workers can perform as productively as the able-bodied. The Nigerian government is attempting to establish some means for altering the attitudes so that these become more compatible with the needs of the disabled persons. (*Obot and Ilondior, 1978*)

Sierra Leone has not made rehabilitation of the disabled one of the government's priorities. As of 1978, there were no plans to provide specialized training to the staff working with the handicapped and no actual vocational rehabilitation centers or cooperative schemes. The only experience with rehabilitation has been with the government sponsored farm craft center for male adults who are blind. Voluntary organizations have catered to the needs of the blind, the deaf, the physically handicapped, and most recently (1974) the mentally retarded.

Republic of South Africa reflects the effects of the industrial revolution and urbanization. The main sources of income have altered from agriculture, fishery and mining; and a capitalistic western-oriented culture has been emerging. With the increasing population and socio-economic changes rehabilitation needs have been intensified. The administrative structure responsible for services to disabled persons is regulated by the National Welfare Act of 1965. The Act mandates that organizations conducting programs for the disabled must register and specify their organizational areas and administration. This includes the federal government departments and private welfare organizations involved in service delivery. Social workers who provide follow-up and after-care services are subsidized by the Department of Welfare and after-care nurses may be subsidized by Provincial authorities. (*South Africa, 1971*)

In order to "disseminate information concerning rehabilitation, to illustrate the integration of the handicapped as an additional source of manpower, to endeavor to remove prejudice against them, and to promote their employment," the Department of Manpower utilization publishes a quarterly magazine, "Rehabilitation in South Africa." (*Rehabilitation in South Africa, 1979*)

Democratic Republic of the Sudan provides services for the disabled population through the cooperative efforts of the government and voluntary agencies. The Ministry of Social Affairs is responsible for the supervision of the voluntary agencies and also of social services for all categories of disabled persons. Institutions have been established throughout the country for the blind, the deaf, for leprosy sufferers, and the physically handicapped. Blind persons are the only disabled group with suitably trained staff; there are very few trained staff members for services to the deaf and the mentally retarded. No in-service or other training exists for the staff except for some specialized training abroad. The government anticipates additional international technical assistance in the future. A National Society for Mental

Health concentrates on scientific research related to mentally handicapping conditions. Sudan's "Five-Year Plan" proposes special projects for the disabled including a survey of the disabled population to identify what additional services are required. (*Barsoum, 1978*)

Swaziland's disabled are provided vocational rehabilitation services by two voluntary organizations, namely: St. Joseph's Rehabilitation Workshop for the physically disabled and St. Phillip's Knitting School for Deaf Girls between the ages of 11 and 18 years-of-age. Other services are provided for such groups as the blind, the mentally ill, the mentally retarded, and leprosy victims. One government mental hospital has 200 fully occupied beds with a professional staff that includes a psychiatrist and a voluntary social worker. The social worker is responsible for the few male patients who voluntarily work in the garden and for the men and women who participate in weaving, sewing, basket-work and in the operation of a small shop. There are no vocational services or follow-up procedures for the resettlement of the patients. Plans for the future include: staff development of instructors as well as of administrators for vocational rehabilitation units; and if finances can be made available a vocational rehabilitation center would be erected. Swaziland also has been considering methods for public education about the needs and potential of the disabled. (*Mamba, 1978*)

United Republic of Tanzania, as does many other African countries, dates the origination of aid for the disabled to the missionary movements. By 1978, there were 24 voluntary organizations providing institutional care and training for leprosy victims, the blind and the mentally retarded. These non-governmental agencies receive annual subventions from the government for their activities. After attaining independence, Tanzania requested assistance from the ILO and as a result of the experts' survey and recommendations the Yombo Vocational Rehabilitation Centre was established. After the disabled persons have completed their training at this Centre, they are resettled in one of the four cooperative workshops. The government funds these cooperatives for three years after which time they can become self-sustaining by registering as "full cooperatives" with the Prime Minister's Office. A "rendering system" enables regional and district governments to offer exclusive "tenders" to the cooperatives for various tailoring and carpentry work. There has not been any systematic staff training except for two fellowships granted in 1974 by ILO. Each year several groups of medical auxiliaries have received a week's intensive course in psychiatry and mental health; then they work under trained doctors or often function independently.

Lack of coordination of services and of trained personnel are crucial unsolved problems. In addition, more accurate statistical data is needed so that suitable planning may be accomplished. Future plans concentrate on the establishment of a Standing Committee on Vocational Rehabilitation that will coordinate the various governmental and non-governmental organizations serving the disabled. Cooperatives are to be expanded, new cooperatives will be constructed, and a vocational rehabilitation center will be established.

Uganda's poliomyelitis epidemic as well as the great number of leprosy infections in the 1950's prompted the establishment of rehabilitation service for the many persons who had become disabled. Missionaries and later voluntary organizations joined the Uganda Government in the expansion of rehabilitation services. After Uganda attained independence in 1963, the government focused on efforts to improve the conditions of the physically and mentally handicapped. Uganda sought assistance from ILO and as a consequence originated the following services:

- 1 industrial (urban) and 5 rural vocational rehabilitation centers
- 4 production (sheltered) workshops
- 1 vocational training center for girls to be trained as domestic workers
- 1 mobile rehabilitation unit (moves to different areas to train disabled women and girls unable to travel to centers because of family commitments)
- 1 shop to sell goods made at rehabilitation centers or by disabled persons in their homes as well as from 2 of the cooperatives that have been established
- 2 resettlement homes for displaced persons with no relatives or no place to live (*Dankaine and Batarinyebwa, 1978*)

The case-finding, registration, recruitment, resettlement and follow-up of disabled persons are the responsibility of the field rehabilitation staff at the district level. At the national level, a National Disablement Advisory Council (voluntary agency) is an advisory resource for the Minister. This National Council is supported at the district level by a Disablement Advisory agency.

The groups for whom services are mentioned are the blind, the deaf, the mentally retarded, leprosy sufferers, and spastic children. Voluntary agencies provide services for these disabled people with some governmental subvention. Administrative activities rather than legislation has established, managed, and coordinated Uganda's rehabilitation procedures. Self-help schemes originated and implemented by various non-governmental agencies have undertaken numerous projects.

Personnel with degrees in social work and social administration or a two-year diploma in social development staff the training facilities. Specialized training in rehabilitation is acquired through on-the-job training, seminars, workshops induction courses and overseas training. (*Dankaine and Batarinyebwa, 1978*)

Front-line personnel are trained as medical assistants for "up-country work." These assistants may aid the general medical officer or the psychiatrist in district hospitals. Their training prepares them to assume a certain amount of responsibility for continuity of care and even of leadership in times of crisis. (*Moser, 1974*) Uganda's future plans include expansion of some of the workshops plus the establishment of additional rehabilitation centers, cooperatives and homes for disabled people. (*Dankaine and Batarinyebwa, 1978*)

Zaire's Kongo has three types of healers who are paid for their services: the herbalists, priests who use herbs and mystic techniques with collective rites, and charismatic leaders who report on their dreams and visions. A fourth type, prophets, do not deal with the fetishes used in the traditional healing processes of the previously mentioned healers. The prophets, who have adopted certain beliefs from the missionaries, are recruited from among the sick and must undergo confession and initiation proceedings. Their methods are of interest to the study of rehabilitation since they establish a community that resembles a therapeutic community and use healing techniques that conform to the Kongo ethos to alleviate the stresses generated by the transition from traditional to modern lifestyles. (*Maharia, 1977*)

Zambia's primary concern with blindness is a consequence of the extensiveness of this disability. Smallpox, measles, malnutrition aggravated by inappropriate traditional medical procedures have been some of the causative factors that have made blindness a major disability. Among the other disabling conditions under consideration by the Zambian Government are: deafness, physical disabilities, mental illness and mental retardation. Treatment, training, and rehabilitation services are to be provided for these people. However, lack of funding hinders the fulfillment of the rehabilitation and resettlement schemes formulated by the Zambia Council for the Handicapped. This Council, a "para-statal" organization operates 13 agricultural rehabilitation centers for the blind and 3 centers for the rehabilitation of former sufferers of leprosy. Cooperative arrangements that were initiated have not been too successful since the families on the arable land allocated to them have not become sufficiently self-reliant. Lack of specialized training in suitable rehabilitative measures for the different groups of disabled persons has impeded the effectiveness of the provisions of services. (*Muma and Bwalya, 1978*) In some locales of Zambia local personnel have been trained as psychiatric medical assistants (mini-psychiatrists) in an effort to relieve the shortage of trained staff. (*Moser, 1974*)

A plan for coordination of services has been arranged through a special committee consisting of the Ministries of Health, Education, Workmen's Compensation, and the Zambia Council for the Handicapped. The Government looks toward the possible appointment of a senior rehabilitation officer at the national level to coordinate and strengthen the rehabilitation program. (*Muma and Bwalya, 1978*)

Zimbabwe is the newly independent nation that until the early months of 1980 was known as Rhodesia. The recently adopted national flag includes a mystic Zimbabwe bird and suggests some of the cultural characteristics that impact on the value-systems, traditions and health practices of this nation. The relics of civilizations many centuries old as well as the Western influences and changing lifestyles that contrast and often conflict with one another make Zimbabwe's problems similar to Haiti. Public attitudes are affected by the African worker's reliance on tribal beliefs and traditions which include witchcraft. The dissimilarity also is apparent in the European's regard for themselves as individuals and the Africans sentiments that stress deep-seated obligations to their units—the tribes or their families as well as the spirits of the departed.

Rehabilitation efforts have concentrated on blindness and deafness and the effect of certain prevalent diseases. Much attention has been focused, also, on the Black workers who make up the majority of the work force. Industrial accidents among this group and the disabling effects of the accidents demand specialized procedures that recognize cultural difference. (*Hunt and Mathews, 1980*) Rehabilitation authorities try to deal with this problem by respecting and seeking to understand ethnic characteristics. Traditional healers continue to be important in the treatment of mental illness and stoical acceptance of disability and other misfortunes are ingrained from generations of hardship. Thus mental health and other problems become a tribal village affair. It is this constellation of contrasts of the old and the new that has made rehabilitation so complex in most of the African countries.

There are several *implications* relating to *rehabilitation of the mentally ill* that may be derived from the preceding survey of 21 African countries.

1. Many disabled people do not receive rehabilitation services in Africa. Chief among this unserved population are the mentally ill. Traditional medicine and some other curative techniques of a more contemporary form are evident in the care of the mentally ill. However, *rehabilitation*, as such, is not discussed as a priority. The primary emphasis is on the rehabilitation of the physically and sensorially disabled. In most African countries, blindness is one of the most prevalent disabilities and has been allotted more attention in rehabilitation plans.

2. The trend is directed particularly to the development of self-reliance of the disabled rather than merely providing them with financial and other support. Thus disabled persons are trained in work-skills and work-habits and assisted in job-placement with the aim of social integration. Work-cooperatives have been established or are being considered as one of the methods for encouraging the autonomy of the disabled persons.

3. There is a tendency towards the enactment of legislation and government intervention in rehabilitative efforts. Collaboration also continues between non-governmental (voluntary) and governmental organizations in the planning, establishing and administering of most services often with governmental subvention and supervision. In some countries the voluntary organizations assume the role or major responsibility for services.

4. Innovative practices in rehabilitative procedures have concentrated on the physically and sensorially handicapped but potentially may be applied in programs for the mentally ill. Some examples of these innovations are:

   - nondisabled workers training disabled persons in specific work skills

- creative work opportunities such as umbrella making that respond to marketing as well as cultural needs
- mainstreaming not only disabled children in the school situation but also the adults in the work situation
- work cooperatives that encourage ownership and self-reliance
- mobile rehabilitation unit that travels to various areas

5. The diversification of cultural orientations represented among the African nations must be recognized. Rehabilitation measures have been unsuccessful when imposed without this cognizance. The different beliefs and value-systems with resultant ambivalent attitudes towards rehabilitation have often interfered with the establishment of rehabilitation services. Although the economic structure of African countries is approaching some level of industrialization and urbanization is increasing—agricultural pursuits and rural living arrangements continue to predominate. For this reason discussions of advanced technologies, methods and techniques have not been particularly relevant to the circumstances of the African countries.

6. Insufficient financial resources and lack of staff are serious barriers to even the initiation of suitable and sufficient rehabilitation programs. Inappropriate and inadequate technical knowledge aggravates this situation.

7. In spite of the adversities, the conflicts, and the contrasting ideologies there seems to be a positive outlook toward the establishment and management of rehabilitation procedures.

Asia

The countries to be included in the consideration of Asia present a wide variety of cultures representing ancient Eastern and modern Westernized influences. Modern medicine primarily exists in urban settings and traditional healing is prevalent in rural areas. This does not signify that the cities lack "healers" of many persuasions. It is not unusual for a person who has not been relieved of symptoms to consult a healer. In fact, Americans who live and often work in certain parts of Asia also consult the shamans and may participate in exorcism to relieve their ailments. (*Spiro, 1975*)

As in Africa, Asia's developing countries have had priorities other than mental illness and except for some countries, rehabilitation for the mentally ill remains a problem. Mental health care has been influenced by a legacy of Western influences—well-intentioned—yet, in supporting a benevolent, custodial approach the mentally ill have been removed from their families and communities. The following survey reveals a multiplicity of practices interwoven with socio-political dissimilarities.

Burma has a wide variety of medical specialists, herbal doctors, astrologers, shamans, exorcists, and many others. Yet, the Burmese peasants narrow their choices for medical care since they rarely consult a modern physician even though they may realize that they are suffering from naturally rather than supernaturally caused illnesses. Supernatural causes are accepted notions for mental disorders and therefore exorcism of the witches, ghosts, or a type of evil spirits (nat) is the primary treatment. The interesting issue is that without psychiatric sophistication, the ceremony performed by the exorcist incorporates certain components that follow psychotherapeutic principles and rehabilitative measures. These are as follows: (*Spiro, 1975*)

1. *Group support*. Since the cultural precepts acknowledge the supernatural as the perpetrator of the patient's abnormal behavior, the person is absolved of blame. This emotional and cultural support from the group is supplemented by the instrumental support of the group's financing the ceremony and by the social support of the sympathetic comments and presence of the group members and the patient's family.

2. *Patient's active participation in the treatment process*. The patient not only observes the rites but also is a participant in them. The exorcism becomes a "symbolic cleansing" through the use of sacred symbols. The placebo effect is apparent in this process since the patient has been socialized to believe in these symbols and in their efficacy. The outcome of the conflict that is staged between Evil (the anti-Buddhist supernatural forces) and Good (the Buddhist forces) obviously is predetermined since the power of Buddhism is all-powerful. With Buddhism on their side, patients are assured of a potent ally that is further reinforced by the exorcist, the family, and the group.

3. *Self-awareness and self-confrontation*. In the permissive, acceptant atmosphere, encouraged by the exorcist and the group, the patient—in an exorcising trance—reveals hidden thoughts of ego-alien wishes. An opportunity is afforded, therefore, for emotional release and absolution.

4. *Personality and role of the exorcist*. The exorcist establishes the facilitating environment. Charisma, empathy, rapport, transference all enter into the exorcist-patient's interactions. The exorcist communicates a firm, supportive and nurturant approach that conveys his self-assurance and courageous confrontation of the supernatural forces.

This example of Burmese traditional "healing" can be an important adjunct in the care of the mentally ill. The cultural necessities that prevail can become partners with modern rehabilitation procedures. The salient message in this description is the easing of the process of social integration when the community is cohered into a source of comfort and assistance.

People's Republic of China is composed of a complex assortment of cultural orientations. Supernatural beliefs are intermixed with Westernized versions of traditional medicine coupled with modern Western-oriented techniques. The classical Chinese view of the world is holistic. Taoist consciousness reflects this view implying a serene awareness of all cosmic phenomena including the diverse functions of the human personality. The Taoists do not separate mental and physical processes and this notion is discernible in most of the procedures utilized with mentally ill people. Herbal potions, diet, the treatment of orthopedic and other "bodily" problems, and acupuncture are aimed to alleviate mental disorders.

Yet, for many Chinese the opportunity for therapy and rehabilitation of their mental illnesses is thwarted because of the stigma of mental illness. The label "mental illness" is disturbing for many Chinese families since this label extends to the entire family. The family potentially becomes unacceptable as a source of young adults for marriage. For these families it means that mental illness is not acknowledged nor responded to early enough. The consequences of this reluctance to seek help often are aggravated mental disorders and difficulties in psychiatric intervention. (*Kleinman, 1975*)

In the following discussion, two metropolitan examples are presented of Chinese practices related to mental illness—Peking, the capital of the People's Republic of China and Shanghai, a seaport.

The private practice of medicine does not exist in China. Physicians are assigned according to the State's needs; and rotation is arranged so that city physicians are deployed to rural areas; for instance, *Peking* physicians are placed in Tibet for one year and in suburban areas for one-half a year—continuously alternating in rural and in suburban settings. The An Ding Hospital and the psychiatric unit in the Peking General Hospital incorporate many of the prevailing therapeutic techniques in China.

Peking An Ding Hospital with 160 beds for adults and children subdivides its clinical approaches into three phases—an acute phase with 24-hour nursing coverage, an intermediary phase with reduced frequency of contact, and an open ward.

Most patients remain hospitalized for an average of three months. Pharmacological treatment (chlorpromazine, tofranil and lithium) as well as electro-convulsive treatment (ECT) and insulin coma as well as acupuncture* and traditional medicine are used. (*Bunney, 1979*)

> Needles are inserted (acupuncture) in the ear for one hour each day, six days a week for three weeks in the treatment of schizophrenia. According to reports some schizophrenic patients demonstrate a dramatic decrease in auditory hallucinations with this treatment. Acupuncture is based on the theory that the insertion of the needles stimulates the endogenous production of opiate-like compounds (endorphins).
>
> Traditional medicine in the Taoist manner considers the whole person in the diagnostic and treatment procedures that use, for instance, herbal products such as leaf compounds in the Peking Hospital and flower compounds in the countryside for psychiatric interventions.

Another approach to a psychiatric setting is demonstrated in the Peking General Hospital affiliated with Peking Medical College. This hospital has a 100 bed psychiatric unit with male and female wards and an out-patients unit. The hospitalized patients are mostly schizophrenic and the out-patient services are provided for neurotic persons and discharged patients. Therapeutic procedures are similar to the An Ding Hospital including both Western and Eastern medical practices, such as—pharmacological treatment, ECT, insulin, acupuncture and massage. In this hospital, the site for needle insertion in the acupuncture procedure is between the eyebrows and patients appear alert and calm during this process. (*Abraham, 1979*)

The plan of care for mental patients in *Shanghai* is the responsibility of the Coordinating Committee for Mental Health composed of medical personnel from the Municipal Bureau of Health as well as representatives from several social agencies, such as: civil welfare agencies and police and district officers. A general survey of 4 million of the residents of Shanghai during 1972–1973 estimated the prevalence rate of mental disease as 7.28% for the urban districts, 6.65% for the rural area with a total rate of 7.28%. The highest incidence of mental disorders was schizophrenia (4.2%) with urban areas indicating the higher percentage of these patients. (*Zhenyi, et al, 1980*)

In order to deal with the problem of mental illness more effectively, Shanghai constructed a mental health network consisting of three levels. This layered organization provides a comprehensive, coordinated service delivery at the municipal, district and community levels. Two municipal hospitals plus 60 to 100 beds in each of the hospitals in Shanghai's ten districts and ten counties are included in this three-level structure. In addition, occupational therapy groups and psychiatric care units provide rehabilitation services. (*Zhenyi, et al, 1980*) Hospitalized mental patients are grouped at different levels according to the severity of their illness; and therapy consists of antipsychotic drugs [usually in smaller doses than in Western countries] ECT, traditional Chinese medicine (herbs) to counteract the side effects of Western medicine, group psychotherapy, recreational, occupational, and socialization therapies and education about mental illness as a preventive measure. Acupuncture with laser beams is practiced in the Shanghai Psychiatric Hospital. (*Abraham, 1979*)

The psychiatric care units for prevention and after-care that have been established in some districts are composed of the patients' neighbors, retired workers and family members. These units report disorderly behavior and the progress in the patients' mental conditions to the health personnel, assist disturbed people with their problems and administer prescribed drugs. Partially recovered mental patients unable to assume the responsibility of jobs are referred to occupational (OT) groups by some of the communes, neighborhood committees and health stations in large factories. Barefoot doctors, paramedics in factories, neighborhood cadres and retired workers observe the patients in the more than 100 OT groups in Shanghai. These supervisors make certain that the patients perform productive work (6 hours daily), that the patients take their antipsychotic drugs and also participate in recreational activities. The comprehensiveness of this plan is furthered by the collaborative steps directed to social rehabilitation by the medical staff in conjunction with family members,

*Additional information about acupuncture is available in Xinzhong, 1979; Schatz, 1979; and Bannerman, 1979

neighborhood committees and the patients' employers. (*Zhenyi, et al, 1980*) The main objective of these efforts is to reduce or prevent relapse using early detection and treatment at the local level as much as possible. (*Abraham, 1979*)

The essence of the success experienced by the three-level plan emerges from the support and cooperation which widens the scope of psychiatric training by educating the lay public through actual participation in the processes of rehabilitation. (*Zhenyi, et al, 1980*) Educational changes also have been incorporated into the medical preparation of physicians and barefoot doctors. Supervision and continuing education have become more important than the initial educational experience. For physicians this has meant recruitment by peer nomination, radical shortening of curricula, and the deployment of highly trained individuals to rural environments as part of their training and also to serve the populace's health needs. In addition, these professionals are assigned the supervision of barefoot doctors and similar workers. An instruction manual for barefoot doctors was prepared in 1970, in two versions—one for the northern and the other for the southern part of China.

An expanded health care staffing pool has been one of the effects of the politicization of medical care. Furthermore, there has been governmental recognition of the continuing impact of traditional Chinese medicine with concerted attempts to integrate these procedures with modern scientific medical methods. The basic framework for planning these health care procedures has been derived from the principles expounded in Maoist slogans—"serve the people"—"self-reliance and group support"—"walk on two legs." (*Agren, 1975*)

Even though **Hong Kong** presents a different political structure than Peking and Shanghai, its Chinese cultural roots are similar. The pluralistic pattern of health services is observed in the two systems of professional service delivery exhibiting dissimilarity in technical orientations and social-organizational patterns. The classical Chinese medical practitioners and the modern Western medical models do not coordinate their efforts. Instead there is a hidden and sometimes blatant demonstration of the competition between the two systems with the Western-trained physicians in the ascendant position and the Chinese medical physician in a subordinate disadvantaged position. One-fourth of the Western-trained physicians and none of the Chinese-trained physicians are employed by the government. These conditions have encouraged uneven service delivery and often insufficient and unsuitable therapeutic practices.

The Hong Kong Government conceived the Green Paper of 1976 and the White Paper of 1977 in order to produce a more complete system of care for the disabled person. These papers presented plans for a ten-year period from 1975–1985 and set forth multidisciplinary programs for treatment and rehabilitation to enable disabled persons to develop their physical, mental, social and economic capabilities to the fullest extent that their disabilities would permit. To achieve this objective the Rehabilitation Development Co-ordinating Committee was established to advise, coordinate and supervise the developing rehabilitation services of the various departments and organizations. Moreover, a Central Registry for the Disabled, probably in the Social Welfare Department, was to be established during 1978 to 1979.

Specific items were included in the Papers to help reduce the shortfalls in psychiatric services, as follows:

- day beds in out-patient and specialist clinics for psychiatric patients
- additional places in halfway houses
- one day hospital for from 40 to 60 patients in every district with a population of around 500,000. Day hospitals would be cost-effective procedures for the mentally ill since the comparative cost of a day bed (in 1976) was estimated to be $37.00 per bed, per day and for the psychiatric hospital the cost was $92.00 per bed, per day (*Hong Kong, 1976*)

Supportive services would be provided for the patients released from the hospital in the form of living arrangements, as needed, accompanied by clinic services with pre-vocational training or retraining, a day center activity arrangement or sheltered employment if necessary, and job placement when feasible. Periodic assessment and follow-up with retraining would be made available in accordance with the person's needs. (*Hong Kong, 1976; 1977*)

The social stigma attached to mental illness had led to indifference and apathy among the general population of the community. These attitudes are reflected in the often repeated comments that the mentally ill should remain hospitalized "until they are completely cured"—"for their own good"—"for society's welfare and safety." Such beliefs do not encourage the establishment of community-based services. Nevertheless the government has developed several centers in the community, such as: The Aberdeen Rehabilitation Center that includes residential facilities for former male and female patients and the World Rehabilitation Fund Day Center. In addition, the Hong Kong Mental Health Association has been administering a halfway house and a hostel for male residents; and the New Life Psychiatric Rehabilitation Association provides services for 170 individuals at any one time.

The New Life Psychiatric Rehabilitation Association started in 1959 as the New Life Mutual Aid Club when they found the group psychotherapy initiated in the Victoria Mental Hospital extremely effective. Fifty-five members and five observers formed the Club and convened monthly meetings. Mutual help became the function of the club members with vigilance of one another to initiate early intervention if a club member should relapse.

Gradually the objectives and the membership increased and the name was changed in 1965 to the present title. By 1976, New Life provided the following facilities: (*Liu, 1976; New Life, 1972*) New Life Male Halfway House; New Life Farm (farm hostel, boarding house, day trainees); New Life Sheltered Workshop; New Life Female Halfway House, Tuen Mun Hostel.

The New Life experiment has been productive. Supposedly "incurable" patients have become gainfully employed decreasing the cost of their care considerably or even completely. Patients previously segregated from and rejected by their relatives have been reintegrated into social places within their family constellation. Hospital beds have been released for acute patients particularly since reinstitutionalization figures have been reduced. (*Liu, 1976*)

The image of health care in **India** follows the pattern of complexity discussed in the previous Asian countries. A dual system of professionalized indigenous and cosmopolitan medicine exists in India with parallel institutions for research, education and practice. For example, in 1972, there were 95 cosmopolitan medical colleges, compared to 99 Ayurvedic colleges, 15 Yunani colleges and 1 college for Siddha medicine. Two research institutes for indigenous medicine awarded Ph.D. degrees as well as D.A.M. (Doctor of Ayurvedic Medicine) degrees. (*Leslie, 1975*) Added to these contrasts are the conglomeration of languages spoken. Although Colonial English is the closest communication system that may be considered a national language, there are 18 major indigenous languages and hundreds of subdialects throughout the country. Even more apparent in this country of 600 million is the wide gap between the rich and the poor and the insufficiency of financial resources to establish appropriate service. (*Gordon, 1979*)

In recognition of the significant impact of traditional healers, India has created ministries on indigenous healing to promote Yoga, Ayurveda, Naturopathy and to study their effectiveness in the treatment and prevention of medical and psychiatric disorders. The National Institute of Mental Health and Neurosciences (NIMHANS) located in Bangalore is the center of psychiatric activity in India. Its programs include outpatient and in-patient services and an innovative plan in which community mental health is associated with health services in a small village. (*Gordon, 1979*)

The central government of India is striving to introduce a "system of primary care for the entire nation—a system of village workers, health aides and health stations which will offer immediate first aid to the most isolated rural Indian and avenue of approach to more sophisticated medical services at the center of or beyond their catchment area." (*Gordon, 1979*) Rehabilitation services continue to concentrate on the physically and sensorially disabled as well as the mentally retarded. Services are organized and administered by the more than 300 voluntary agencies and the Department of Social Welfare. (*Roy and Basu, 1980*)

Mental health services have not changed much. The 36 mental hospitals continue to stress custodial care in buildings that for the most part are barrack-like structures. Perhaps most discriminatory are the provisions for admission, care and treatment regulated by the Indian Lunacy Act of 1912. This Act has a built-in class system in which ability to pay for hospital care determines placement and the efficacy of therapeutic measures. (*Taylor and Taylor, 1970*) Furthermore, most mental health facilities do not distinguish between the mentally ill and the mentally retarded. Thus there rarely is a distinction in the therapeutic and developmental approaches to be applied. One agency with differentiated mental health services is the Indian Institute of Mental Health and Human Relations which concentrates on psychotherapy for all age groups with the objective of promoting mental health.

One suggestion that would provide rehabilitation programs for the mentally ill has been offered by Shrivastava (*1978*). He recommends the establishment of a "multi-category workshop for the handicapped" in which all categories of handicaps (including the mentally ill) would be served. Thus this facility would integrate a multitude of services with a multi-disciplinary approach directing efforts toward training in a wide variety of occupations and trades. Perhaps then India might move a little closer to the provision of services to each and every handicapped person. (*Shrivastava, 1978; Roy and Basu, 1980*)

The **Indonesian** government realized that the changing practices related to the therapy of the mentally ill continued to accent the relief of the symptoms of the disordered behavior but failed to assure that the discharged patient would be able to remain in the community. Because of this awareness of unsuitable results with high relapse rates the Government implemented several plans in the 1970s. One of these was the organization of a coordinating committee to devise a system of regulations governing rehabilitation for the protection of the physically and mentally disabled. (*Moedjiono, 1976*)

The establishment of a rehabilitation program is not a simple matter in Indonesia because of the negative attitudes toward mental disorders of the patients' families, the community and even professionals. Other constraints also hinder efforts—lack of funding, the development needs of the country, the general problem of unemployment, and the fact that many of the patients are uneducated and unskilled. Although the lower classes seem somewhat indifferent to their relatives who have been institutionalized, they seem to be able to tolerate their presence in their homes with less social impediment and embarrassment than those relatives from the middle and upper classes. (*Tjahjana, 1976*) Patients from more affluent circumstances are more likely to be hospitalized in private mental hospitals and to remain in the hospitals for shorter periods of time. Whether this is primarily because of the more appropriate and effective services or because of the high cost to the family is difficult to assess.

For all of these factors of prejudices, finances, priorities, rehabilitation of the mentally ill is in its embryonic stages in Indonesia. One example of the more carefully designed rehabilitation program is conducted at the Bogor Mental Hospital for chronic mental patients. After the in-patient admission procedures in which the family states that they would be responsible for nursing expenses and would accept the patient upon discharge, the remainder of the system includes: preparation, placement, and supervision. This plan is implemented by means of a multi-disciplinary approach with the goal of providing a

systematic plan for returning the mental patient to society as a self-supporting and useful citizen. The steps of this plan contain the following: (*Kuntjoro, 1976*)

> *Preparation*—medical treatment, nursing care, physical activity, psycho-social retraining and vocational training, work therapy, group therapy, music therapy and family cooperation are incorporated in an individualized program.
> *Placement*—selection team evaluates the patient's readiness and determines whether the patient may be discharged and placed in a job or in a sheltered workshop.
> *Supervision*—observation and monitoring of the patient's activities are continuous from the moment of the patient's admission to the hospital to after-care when the patient is discharged. A staff member visits patient at his home and group therapy sessions are conducted at the hospital periodically.

Another direction taken by Indonesia's Ministry of Health emerged from the Ministry's recognition that psychiatry alone could not fulfill the needs for mental health and for assuring the mentally ill person's return to the community. A group of staff members were assigned to a project entailing the preparation of a manual to train basic health workers. These staff members collaborated with WHO personnel to write a manual in simple words unencumbered by medical/psychiatric jargon. Indigenous workers would use this manual for information about such aspects as: first aid, the recognition of symptoms of certain infectious diseases and of mental disorders. By a careful step-by-step task analysis, the workers would be trained to perform the essentials of treatments that might safely be accomplished by non-physicians. Thus Indonesia hoped to fill in staffing needs that available psychiatrists were not able to fulfill.

The **Iranian** Government directed its attention to a new role for NIRSD (National Iranian Society for the Rehabilitation of the Disabled) at about the same time in the 1970's that Indonesia was initiating several changes in procedures. NIRSD (established in 1967) was assigned the responsibility of the administration of several psychiatric hospitals in 1974. By 1976, the budget for treatment of the mentally ill was increased "tenfold." The Society was able to recruit most of the returning foreign-trained Iranian psychiatrists, and initiated planning for a comprehensive delivery system to suit mental health needs. The first two community mental health centers were opened in Tehran in 1976 providing emergency assistance, diagnosis, in-patient treatment, suicide prevention, day hospitalization, and research and rehabilitation workshops. Training for some of the mental health workers was also made available. (*Rehabilitation Iran, 1976; Shashaani, 1980*)

In order to coordinate the community-based centers with the hospital admissions policy, all applicants for hospitalization had to be processed through the CMHC. Social insurance payments would be provided only for patients referred through the CMHC for hospitalization. Future plans for facilities have concentrated on a network of community mental health centers to provide psychiatric care in each catchment area of from 100,000 to 200,000. Training programs to staff these centers began in 1976. Further plans look toward the establishment of a psychiatric rehabilitation village for 900 chronic mental patients at the Razi Hospital and the addition of other locations on a gradual basis. (*Siassi, 1976*)

Israel's population represents an aggregate of people many of whom have and continue to relocate from the developing countries of Africa and Asia and also some from the more developed countries. Population has more than tripled since Israel's establishment in 1948; and it is currently beset by the problems of other nations—inflation, increasing crime, and housing problems as well as the prevalence of handicapping conditions among its inhabitants. Rehabilitation efforts have been intensified because of the effects of war, the high incidence of disabilities complicated by the lack of vocational skills. Services for disabled people have been initiated by both governmental and voluntary operated programs for such categories as: war injuries, chronic diseases, blindness, mental retardation, mental illness, and so on.

Psychiatric units in general or government hospitals, psychiatric hospitals, mental health clinics, hostels, work villages and comprehensive community health centers are administered by the Mental Health Service of the Ministry of Health. The organizational structure of this Service consists of a central office, district offices in four locations of Israel and further supervision for operating units at the local levels. The expanded program of community-based services occurred in the 1960's. The current emphasis of rehabilitation procedures is on the development of independent functioning and the return to employment whenever feasible. Former hospital patients who continue to need a protected environment are located in work villages which are open communities that encourage the ex-patient's involvement in work or other activities in the "outside" community. Retraining of work skills as well as resocialization are offered in these villages. Each client's successful rehabilitation is determined by an individualized assessment of potential functioning capacity. No person's "case" is ever "closed." Instead, most persons are followed for the remainder of their lives and are afforded intervention techniques in times of stress. (*Reagles, et al, 1974*)

The trend toward altering hospitalization so that it assumes increased rehabilitation orientation and activities is exemplified in a two-year pilot project at the 100-bed Shalvata Psychiatric Center in the pastoral setting of the northern outskirts of Tel Aviv. In 1976, a rehabilitation psychologist joined the hospital staff and set about to organize procedures for the hospital patients greater involvement with the surrounding community. This necessitated staff members moving into the community to establish "bridges" for the patients ease of entry to community activities. The purpose of the administrative changes was the centralization of rehabilitative processes using only the existing personnel. (*Moss and Davidson, 1980*)

An innovative program was instituted encompassing six areas of vocational and social rehabilitation: activity therapy/rehabilitation groups, vocational guidance unit, after-care therapeutic clubs, in-hospital rehabilitation consultation, liaison activities with community-based facilities, and job placement. (*Moss and Davidson, 1980*) Because this rehabilitation process begins within two to four weeks after the patient's hospitalization, the goal for each individual becomes focused on relocation in the community rather than continued hospitalization.

From reliance on shamanistic treatments*, massage, hot spring baths and moxibustion*, **Japan** has developed a professional medical establishment that is almost wholly western in its orientation. Treatments and practitioners utilizing native medicine persist but are no longer recognized as "medical" by the government or by the majority of the population (*Pelzel, 1975*). The adoption of western mores in Japan has in many ways surpassed the Chinese even to the extent of lessening some of the Japanese cultural characteristics. It is interesting to note that the hallucinations of the Japanese suggest an incorporation similar to their westernization. Thus, the Japanese patients become someone else or something—believing they are possessed by or transformed into other people or gods living or dead, or, perhaps, the sun or the moon (*Miyamoto, 1979*). In spite of westernization, the Japanese continue to be influenced by animistic perceptions of nature which may conflict in the treatment/rehabilitation process.

Two supports are offered to the mentally ill person that aid in rehabilitation—the family and financial assistance. In spite of the many westernized changes Japan continues to respect the family unit which often affords a haven. This focus on the family is reflected in a favorite Japanese slogan "All under the sun-one family." (*Miyamoto, 1979*) When an individual becomes mentally disordered hospitalization is available in one of the three large public psychiatric hospitals or in the more numerous private psychiatric facilities. The National Health Insurance provides some degree of financial assistance for treatment and rehabilitation.

Most of the rehabilitation programs in Japan are tax-supported and most of them concentrate on rehabilitation of the physically handicapped. The Law for Welfare of Disabled Persons (1950) regulates the medical and welfare services for the physically handicapped; and the Workman's Compensation Insurance Law (1947) specifies rehabilitation and compensation services for work-related disabilities. Additional legislation related to vocational rehabilitation are: the Employment Security Law (1947) and the Physically Handicapped Person's Employment Promotion Law (1960). Both the latter laws are administered by the Ministry of Labour. A quota system is part of the 1960 Act but employers only are strongly recommended to employ the handicapped and are not punished if they do not fulfill their quota. Vocational training is provided at the vocational training centers and employers are responsible for on-the-job training. (*Koike, 1975*)

Shamanistic treatment—a form of folk-healing performed by a priest or medicine man based on the belief of good and evil spirits who only can be influenced by the healing rituals of shamans; *moxibustion*—burning on the skin of moxa (soft, downy plant material) to treat various diseases and disorders.

Relatively few out-patient community mental health or any form of day therapy facilities exist in Japan. Some of the programs utilize aspects of the Japanese culture and many others follow a western model. The Morita Therapy practiced in Japan exemplifies the holistic health concepts supported by Japanese philosophy. This therapy provides a residential program that is non-medical and that stresses peer counseling as an important part of the process of rehabilitation.*

In contrast to many of the Asian nations, the voluntary organizations in Japan assume much less responsibility for rehabilitation than the government. "It may be peculiar to Japan that fund-raising has not been popular. . ." (*Koike, 1975*) Voluntary organizations perform publicity activities rather than provide direct services.

The **Kuwait** Ministry of Social Affairs and Labor is responsible for a Vocational Rehabilitation Center which combines physiotherapy with training in a collaborative staffing arrangement with some hospitals. This rehabilitation program concentrates on persons who are physically and sensorially disabled. After training, the Center and certain Ministry departments arrange for placement of the disabled person in a government position or in the Production Workshop associated with the Center. Workers at the Production Workshop are paid according to the number of products they complete and this salary is supplemented by funds as mandated by the Law for Public Aid. The Department of Social Service, School Health, and Public Health provides medical, psychiatric and social services for the handicapped. Education of all citizens was mandated by law in 1965. The Kuwait Government perceives education as the cogent means of furthering not only each individual but also the state's progress. (*Ministry of Social Affairs, 1980*)

Attention to rehabilitation procedures is a recent phenomenon in **Malaysia**, particularly in its application to the mentally ill. The medical model that prevailed for patients in psychiatric hospitals did not support an emphasis on social or occupational rehabilitation. Therefore, neither the hospitalized patients nor the discharged patients received very much, if any, rehabilitation. In 1967, the newly established Psychological Medicine Unit associated with the University (of Malaya's) Hospital initiated weekly group psychotherapy sessions for recovering patients in conjunction with a few patients previously discharged. At first the primary criterion for selection was the patient's or ex-patient's ability to speak English. Later patients who were able to speak Bahasa Malaysa were added as participants; and, occasionally a patient speaking other languages would join the group to profit from nonverbal cues.

*Personal communication with Diana Woods of World Rehabilitation Fund, 1980

At the beginning, the group process did not focus on occupational or social rehabilitation. An increase in staff in 1971 was the springboard for establishing the Psychiatric Day Centre with five chronic schizophrenic patients. The number of participants grew from 8 to 14 as the program progressed and the Day Centre continued to expand its activities evolving as the only place in the Federal Territory that offered rehabilitation to psychiatric patients. For five days of the week, the rehabilitation activities consist of psycho-social group proceedings, such as: group psychotherapy, sociodrama, occupational therapy, cooking, art, group singing, swimming and relaxation classes with periodically patient-arranged parties to which relatives and ex-patients are invited.

A year later with the financial aid of the Malaysian Mental Health Association, the Home Industry Project was begun. This Project was a craft-oriented occupational therapy arrangement until later contacts were obtained from local industries. The type of work was expanded and patients were paid at the rate of one-half to two-thirds the pay rate.

Several problems were encountered in the implementation of the rehabilitation activities that flowed from the lower esteem afforded the rehabilitation units. Staff coverage was difficult because many staff members did not consider supervision in the rehabilitation unit a necessity. Physicians' referrals of both in-patients and out-patients were infrequent. Administrative regulations did not permit the staff to assume responsibility for patients outside the hospital and so outings of any sort were banned. Limited space decreased the number and spread of activities. Yet, in spite of these disadvantages, there were several compensating advantages, such as: psychiatric patients were able to intermingle and participate in activities with non-psychiatric patients to their mutual benefit; staff members from other hospital units were able to become acquainted with rehabilitation as applied with psychiatric patients; and trainee psychiatrists added knowledge about rehabilitation to their training. (*Deva, 1978*)

In Sarawak, a state of Malaysia, catchment populations of 17,000 are served by twenty-bed psychiatric treatment centers that are staffed by three hospital assistants, four assistant nurses and five psychiatric attendants. The hospital assistants are trained in patient management at the Sarawak Mental Hospital to conduct follow-up treatment of mental patients. A psychiatrist vists the centers as a backup and for discussion of problems with patients. (Moser, 1974)

In **Pakistan**, Lahore Fountain House (Chaudry, 1977, 1978; Mirza, 1978) represents an innovative effort to curb the relapse rate of mentally ill patients. Three out of ten discharged patients return to the mental hospital. The families of these patients are confronted with these recurrent mental disorders and many are confused and frightened because they believe that spirits (usually Jinn) repeatedly have possessed their disturbed relatives. Mental health professionals, who most frequently have been trained in the United Kingdom or the United States, are opposed to the erection of additional hospitals. Intermixed with this contemporary viewpoint is the continued existence of the custodial ideology that persists in most of the overpopulated mental hospitals. Insufficiency of facilities, contrasting ideologies and the concentration of the sparse number of available psychiatrists in urban settings confounds service delivery for the mentally ill.

With the financial and technical assistance of the former United States Department of Health, Education and Welfare, the Lahore Fountain House was established in 1971. This House aimed to demonstrate community-based procedures that would rehabilitate discharged mental patients so that they might be better prepared to cope with living "outside" the hospital. The House was patterned after the Fountain House in New York with modifications in accordance with local cultural and social conditions. The criteria for membership were that the participants must be males between the ages of 18 and 40 who were not physically disabled or drug addicts and whose diagnosis was "schizophrenia." The program at the House included:

- vocational training in several different units, such as: clerical, flower-making, plaster of Paris modeling, carpet weaving, handicraft, carpentry, electrical, framing, snack bar, kitchen (shopping, cooking), house maintenance (cleaning, repairing). The objectives of these units are to expose the participants to a variety of work settings and daily living necessities, to strengthen work habits and skills, and to afford the staff a variety of opportunities for observation of the members for counseling. Each unit has two leaders—one from the staff and the other from the membership.
- employee members program which begins when the member's schizophrenic symptoms have subsided. Then they become "employee members" and thus part of the staff.
- reinstatement to former jobs. The staff of the House contact former and potential employers and follow the members at their job placements until they are comfortable at work and are performing satisfactorily.
- transitional employment program. This is a particularly creative approach to easing the member into the work world. One job is shared by two members each working half-a-day under the supervision of a social worker from Fountain House, Lahore. The supervisors have become familiarized with the job by actual on-the-job work experience prior to actual placement of the member.

The professional staff and the members work together within an atmosphere of mutual helping. When the members are able to be self-reliant they leave the House but many return periodically, sometimes for consultation. The results of the members' rehabilitation have been favorable as evidenced by better family relationships, satisfactory work adjustments, and reduced relapse rates.

Singapore has four psychiatric facilities for hospitalization. Woodbridge Hospital, which is the main hospital, has 2,300 beds and operates 14 psychiatric sessions in various locales in Singapore. View Road Hospital, with 250 beds for schizophrenic patients concentrates on rehabilitation. There also are two other facilities—a Child Psychiatric Clinic and a ward in Changi prison for forensic psychiatric patients.

Woodbridge Hospital expanded its services to an out-patient clinic one year after the introduction of chlorpromazine in 1953. More than a decade later, in 1965, a rehabilitation committee was formed to construct plans so that patients might be prepared to be relocated in the community with the goal of independent living. After the planning stage several rehabilitation projects were initiated at the hospital, such as: farming and horticulture, industrial work, domestic training, occupational therapy, car-washing, and hospital work. The stages of rehabilitation included: habit training (personal hygiene, work habits), individualization and socialization, education and preparation for reintegration into the community.

An Employment Subcommittee assists patients who are sufficiently rehabilitated to become employed. These patients register with the Subcommittee so that they become part of the follow-up process. The Subcommittee contacts prospective employers to establish job opportunities; then assists the patients before and after job placement as long as necessary. (*Tsoi, 1976*)

Several problems were encountered in the rehabilitation of the chronic schizophrenics involved in this project. The behavioral characteristics of schizophrenia often hinder the patients' acceptance in the community and are a barrier to stimulating the patients cooperation in the activities of rehabilitation. The "institutionalized personality" that develops through the years of hospitalization reflects the lack of motivation, initiative, passivity and dependence reinforced by custodial care. All of these characteristics encourage rejection and abandonment by relatives and the community. (*Tsio, 1976; Choo and Lee, 1976*) The Singapore Government is aware of the seriousness of this rejection and The Minister of Health has "appealed to the families wherever possible to take home their relatives and not leave them unvisited in the hospital." (*Chandran-Dudley, 1975*) Added to these difficulties is the fact that the medical staff frequently does not perceive the non-medical methods of rehabilitation as valid procedures in "curing" the patient. Therefore, in order to establish an appropriate and accepted rehabilitation, program procedures for change must go beyond the patient to the hospital staff, the family and the community.

Rehabilitation as an important aspect of care in Singapore has been officially recognized since 1969 when the Rehabilitation Unit chaired by the Permanent Secretary, Ministry of Social Affairs was established. Collaborative efforts at planning and implementing programs have been effected by the Ministries of Social Affairs, Finance, Education, Labor, Health and the Singapore Council of Social Service. However, as in many other countries in Africa and Asia, services for the disabled have been developed mainly through voluntary efforts. For instance, in 1976, the Singapore Association for Mental Health, a voluntary agency, planned for a Mental Health Centre in which consultations, counselling, group therapy and other activities would be conducted; and for "half-way flats or half-way houses" where female patients who had been discharged from the hospital would be able to become gradually adjusted into the community. The team approach has been supported as the most practical in solving the problems of rehabilitation so that facilities might be shared rather than duplicated and interagency communication might be fostered. (*Chandran-Dudley, 1975*)

In **Sri Lanka**, voluntary organizations have always assumed leading roles in providing services to disabled persons in the forms of: institutional care for the severely disabled, the organization of educational facilities, and in vocational training. These services have complemented the activities and coordination of the government. The Ministry of Health and the Department of Social Services partially fund the voluntary organizations and these agencies raise additional funds by means of fund-raising activities.

Most of the rehabilitative efforts were focused on the physically handicapped until the 1970s when voluntary organizations centered their concerns on better facilities for the mentally handicapped. The government supported these efforts and assisted in the organization of the programs. Public apathy has decreased, the disabled have become more independent and many more are gainfully employed. Yet, success in employment of the disabled continues to be limited. Therefore, the government has been considering legislation to encourage more extensive accomplishments in rehabilitation specifically in job opportunities. In order to avoid the difficulties encountered in the implementation of quota-employment laws, the government also is directing attention to training disabled persons to be self-employed or to the discovery and creation of non-traditional employment opportunities (Gunawardane, 1975).

The religion-related healing practice of shamanism still exists in **Taiwan** particularly in the rural areas. The dang-gi (divining youth who practices shamanism) is assumed to possess the powers to communicate with the gods and in a trance-like state acts as if possessed by a god. It is in this state that he is "able" to assist people with a wide scope of psychiatric problems (except for the major disorders). The general psychological problems of the lower and middle classes usually are handled by the drawing of bamboo sticks (chou-chien or divination). Fortune-telling (suan-ming) and physiognomy (k'an-hsiang) are usually the preferred methods for the middle and upper classes. Since modern psychiatric and counseling procedures are available only in the city, these methods are more accessible for the middle and upper social classes who are more likely to be urban dwellers. It is interesting to note that sociocultural and political forces have hindered the occurrence of alcoholism and drug abuse (*Wen-Shing, 1975*).*

> *Throughout all forms of care there is a common tendency to emphasize compliance, harmonization and regulation as the means for obtaining a condition of normality. There is less emphasis on conquest, mastery or improvement, which may be stressed in other societies.* (Wen-Shing, 1975)

Taoist ideology emphasizing harmony and regulation in the natural world is the framework for Chinese psychiatric care.

*Wen-Shing, T., Traditional and Modern Psychiatric Care in Taiwan, In Kleinman, A., et al, editors, Medicine in Chinese Cultures, DHEW Publication N. (NIH) 75-653, Washington, DC, United States Government Printing Office, 1975, 177-194

The great concern with the family system must also be attended to in any therapeutic/rehabilitative procedures in Taiwan. This does not refer to the immediate family but also to the mentally ill person's ancestors among the rural population particularly. Finding the cause of the illness is also crucial to the relief of symptoms and the lessening of anxiety of the patient's family. This cause may be explained by the supernatural within the cultural experience of the patient and the family. (*Ahern, 1975b*) Chinese-style doctors seek the causes and base diagnoses on "feeling the pulse or studying the complexion and dispense herbs or other substances from an extensive pharmacopoeia. . . Western-style doctors diagnose with the help of instruments such as stethoscopes. . . . and dispense powders, pills or injections. . ." (*Ahern, 1975a*) The link between all of these aspects is the search for causes that can be conveyed to the patient and to the family. For many of the people of Taiwan the explanation of the experience of illness is more important than the method of cure.

The number of disabled people increased significantly in **Thailand** as it did in other countries after the second World War and brought sharper attention to the need for rehabilitation. Several governmental departments and voluntary organizations are involved in the provision of services for the disabled. These are, as follows:

- Public Health Department, Ministry of Interior--institutions, training for occupations in the workshops in the institutions. Public welfare offices are located in almost every province to assist the disabled.
- Department of Labour, Ministry of Interior—job placement
- Special Education Department, Ministry of Education
- Ministry of Public Health—prevention and treatment of disabilities
- War-Veterans Organizations—workshop for disabled war veterans
- Voluntary institutions with workshops—for crippled, blind, deaf, and for mentally retarded. Partly financed through the Public Welfare
- Council on Social Welfare of Thailand—coordinates governmental and voluntary organizations

The legislation related to employment of the disabled is outdated but the Ministry of Interior has ordered every government office to employ qualified disabled people. (*Chanteratim, 1975*) It is interesting to note that "willingness to be rehabilitated" is among the eligibility criteria at the Rehabilitation Training Center for the Disabled.

In several ways the *implications* relating to rehabilitation of the mentally ill in Asia are similar to those in Africa since developing nations exhibit comparable problems, such as: rehabilitation of the mentally ill is not discussed as a priority; voluntary efforts often are predominant in the encouragement, establishment and provision of mental health services and collaboration frequently is evident between governmental and voluntary organizations; insufficient financial resources and lack of staff hinder rehabilitation programs; and there is, nevertheless, a positive outlook supporting the establishment of rehabilitation programs. The following are additional implications derived from the survey of the 16 Asian countries:

1. The elements of fear and rejection of the mentally ill continue to be particularly strong among some of the cultures such as in China in which the stigma of mental illness extends to the entire family. Frequently this attitude encourages concealment of the mentally ill relative, delay in obtaining services and greater difficulty in rehabilitation.

2. Western-oriented and Eastern-oriented therapeutic methods exist separately, or coordinately, or competitively. There are dangers in all three procedures if the therapists' methods do not recognize the culture-specific definitions of disorder, curing, and ideas of therapeutic change. (*Higgenbotham, 1979*) Attempts to resocialize the mental patient to norms that markedly differ from the family and community of origin has potential for culture-shock, may interfere with the flow of social relationships and consequently lead to lack of cooperation by the patient (and the family) in the therapeutic/rehabilitative process. This view is reflected in the previous discussion of the people in Taiwan and their desire for explanations of causes rather than an emphasis on cures. These cultural orientations may also clarify the rejection of the approaches of the indigenous professionals who were trained "overseas." Their "ways" become too foreign and do not respond to their own community's needs. Higginbotham (1979) proposes the construction of an Ethno-Therapy and Cultural Accommodation Scale (ETCAS) as a foundation for planning culture-specific technical assistance to the developing countries.

3. The "last resort"—"no hope"—custodial view that initially isolated the psychiatric hospitals persists among the people and often among the professionals in the Asian countries. In some instances, such as the Lunacy Act of 1912, a class system of institutional placement and types of care is established. Thus legislation further segregates the mental patient.

4. The methods of traditional healers can be analyzed and categorized according to psychotherapeutic and rehabilitative principles. An example of this analysis was cited in Burma. The extension of such analysis to various other healing methods would be useful. Furthermore, research efforts directed to determining the physiological bases for traditional medicine such as acupuncture, yoga, and the like would identify those components of traditional medicine and western techniques that can be linked together in accordance with scientific methodology. The People's Republic of China (PRC) has initiated such attempts to coordinate Eastern and Western medical and rehabilitative processes.

5. Some of the innovative approaches described in the Asian countries surveyed are as follows:

The three-level organization of the mental health network in Shanghai;

The training of indigenous workers as health and rehabilitation personnel in PRC, Iran, and so on;

Community-based rehabilitation facilities that include creative training, counseling and social processes:

- The New Life Psychiatric Rehabilitation Association in Hong Kong
- Fountain House, Lahore in Pakistan

Work villages in Israel

The Ministries of Indigenous Healing in India to study the effectiveness and to promote yoga, ayurveda, and the like;

In-hospital rehabilitation plans that coordinate in-patient with out-patient goals:

- Bogor Mental Hospital—Indonesia
- Shalvata Psychiatric Center—Israel
- University Hospital associated with the University of Malaya
- Woodbridge Hospital in Singapore

Australia

The Commonwealth Government of Australia stresses four principles in its provisions of services to disabled persons. These are: income maintenance, improvement of services, support of voluntary organizations and consultation with the handicapped to determine priorities as they perceive them. These principles have been established in recognition of the individuality of each disabled person rather than relegating them to the generality and categorization of "groups" and "group needs." In order to further these opportunities for rehabilitation, the Government, in 1977, extended free-of-charge rehabilitation to all disabled persons of working age regardless of whether they would be candidates for paid employment. Housewives, particularly from lower income groups, also became eligible for rehabilitation assistance. More services rather than more surveys are currently the focus of rehabilitation efforts.

A three-tiered system consisting of the Commonwealth, the States and Voluntary organizations is responsible for the provision of services. Voluntary organizations are funded by the Commonwealth through the Handicapped Persons Assistance Act (1974). The government plans to increase funding to these organizations but is cautious to "strike a balance between preserving the incentive for community involvement and ensuring that effective groups do not go without adequate funds." (Guilfoyle, 1978) Self-help organizations, such as G.R.O.W./Recovery provide social and emotional assistance for people unde. psychological stress. Several other non-governmental and governmental agencies are responsible for implementing the services provided for handicapped people as for example the following: (*Garside, 1975, Guilfoyle, 1978*)

The Australian Council for Rehabilitation of the Disabled (ACROD) is the umbrella organization for groups offering services for handicapped people and acts as a liaison channel between the voluntary sector and government. The National Committee on Housing and Residential Services is a subdivision of ACROD that supports and assist the implementation of alternative community living arrangements such as hostels. (*Gleeson, 1977*) ACROD produces several publications regarding Australian rehabilitation projects and services as well as activities of special interest gathered from foreign countries.

Associations concentrating on special groups, such as: the Australian Association for the Mentally Retarded, The Association for Mental Health, the Australian Council for the Blind, and others concerned with deafness, quadriplegics, and multiple sclerosis sufferers are partially funded by the government and are within the coordinating network of ACROD.

The National Advisory Council for the Handicapped reports to the Ministry for Social Security. This Council seeks to develop State level advisory mechanisms to help in the coordination of services for the disabled.

Several governmental organizations responsible for the administration of legislative regulations providing several forms of service for disabled persons regularly consult with the Inter-Departmental Committee on Rehabilitation.

Rehabilitation services based on individualized program plans are provided in both residential and day attendance centers in the six mainland capital cities of Australia. Physicians, nurses, occupational therapists, social workers, vocational rehabilitation counselors as well as tradesmen assist in the provision of services. Work Adjustment Centres prepare disabled persons for employment. These centers have been developed in cities, such as: Sydney, Melbourne and Brisbane; and Work Preparation Centres (in Melbourne and Sydney) assist handicapped young persons who have left school. In addition, the number of Sheltered Workshops have expanded. These Workshops are operated by

voluntary organizations which receive a capital subsidy of four dollars for every dollar they raise and a staff salary subsidy of 100% for new ventures which is reduced to 50% later. Incentive rewards of $500.00 are given to voluntary organizations for each disabled person who has been rehabilitated and placed in open employment and remains employed for a period of twelve months. The more severely disabled persons participate in Activity Training Centers. (*Guilfoyle, 1978*) Beyond the services they offer, the voluntary organizations have been of significant impact as the "conscience of the nation." They have pointed out deficiencies in services for the disabled and ways in which these can be met. (*Garside, 1976*)

The Association for Mental Health in Australia is active in supporting and initiating services for the mentally ill, their parents and relatives. Lukes (1976) advocates for the development of parents and relatives as primary care-givers and mental health specialists. She contends that their emotional involvement with their mentally ill relatives makes the difference in the kind of care offered. Psychiatrists "have been slow to warm to the genuine mutual interaction. . ." (*Spencer, 1976*) and instead have developed distancing techniques so that they may not become too attached to their patients. Luke's experience with groups of relatives and friends confirms their value in the rehabilitation of the mentally ill. She perceives community responsibility originating with those whom the mentally ill persons affect most—their family and relatives, "but supported and encouraged by the professional care-givers in this field, psychiatrists, the social workers, the psychiatric nurses and field workers."

Australia has made many changes in the delivery of its system for rehabilitation and has devised plans for the future expansion of its services—yet, Australia is confronted with problems prevalent in other parts of the world. Lack of trained psychiatrists and other mental health professionals plus the restrictive effects of a depressed economy have curtailed the funding of services. (*Garside, 1975*) Although the level of poverty is not as high as in some other countries, problems are aggravated by the high morbidity rate of the aborigines who are one percent of the general population and by the migrants who represent twenty percent of the population. Migrants appear to be particularly prone to cerebrovascular ailments and schizophrenia. (Howells, 1980) Channels for remedying these difficulties are under consideration.

New Zealand, a country espousing an egalitarian ideology, has been evolving from a constellation of relatively rural communities and urban areas with the emergence of a large Maori urban working class. It is a country of over 3 million people in the Southwest Pacific about 1300 miles east of Australia. Two of the predominant cultures are the Pakehas (European settlers) and the Maoris. During the 1970's there was renewal of the Maori's interest in its traditional customs and values as well as its reassertion of claims to land tenure and ownership.

Although the traditional beliefs of the Maoris have been modified by their contact with the Pakeha culture, the Maori's concepts of health and illness continues to interject supernatural explanations based upon the evil god Whiro. These explanations conceive of both physical and mental illnesses as the outcome of violations of topus (rituals). Psychiatric disorders, as determined by hospital admission rates, were lower among the Maoris than among the Pakehas until the 1960s when urban socioeconomic structures gradually increased and Maoris' were exposed to the Pakehas more closely and frequently. These changes conflicted with traditional cultural orientations, exacerbated stress, and affected the rehabilitation of the Maoris who became mentally ill. Therapeutic/rehabilitative measures that recognize the mores and beliefs of the Maoris are essential. In fact, trained Maori mental health workers need to be incorporated into the mental health services. Efforts to recruit and train such personnel have already begun (*Adam and Wintrob, 1977*).

Free medical care is available at public hospitals and prescription drugs are also free. Except for private medical care, health services are available for all people no matter what their socio-economic level. The following mental health practices are some of the more promising efforts: (*Dowden, 1980; Adam and Wintrob, 1977*)

In the early 1970's the New Zealand Government acknowledged the gaps in mental health services and began working towards the expansion of general hospital psychiatric units and community health services. A Government White Paper directed that the rehabilitation services should become the responsibility of the regional health authorities; and the administrative control of services should be vested in the local hospital boards rather than the Department of Health. A Health Services Advisory Council was initiated to develop a comprehensive plan.

The Ashburn Hall, a privately endowed psychiatric hospital was organized as a therapeutic community. It has been approved by the Mental Health Division so that patients may have part of their payments paid from the State Hospital Benefit.

Self-care and work therapy have been incorporated as part of the rehabilitation plan in some hospitals as well as domestic therapy for housewives and industrial therapy for the individuals with the potential for returning to work. Through these efforts the patients are involved in everyday routines and the staff are afforded the opportunity to assess the patient's coping and work skills.

Manaroa is a mental health clinic in Palmerston North that is an example of a community mental health center and may be used as a model for future centers.

A few innovative community teams have been organized to accomplish primary screening of psychiatric patients. These teams are composed of a public health nurse, a social worker, and sometimes a clinical psychologist.

Community homes, hostels, half-way homes, and day hospitals are some of the community-based living arrangements and services that are being made available with home visiting services by psychiatric social workers, psychiatric nurses, and the like.

The Mental Health Foundation (1974) sponsors projects for demonstration and research in mental illness and mental health with the aim of discovering more effective procedures for prevention and rehabilitation.

There can be no doubt that the process of rehabilitation has gained increasing importance in New Zealand. However, this country as many other countries is hindered by insufficient trained personnel and the gaps of community services for the rehabilitation of the mentally ill.

There are cultural and socio-economic *implications* that emerge from a survey of services for the rehabilitation of the mentally ill in the countries of Australia and New Zealand that set these countries apart from the previously discussed countries. Yet, one glaring repetitive similarity with Africa and Asia persists—rehabilitation services are desired for the mentally ill but the initiation and implementation of such services continue to exhibit more significant gaps than services for other disabilities. There are important advancements in the recognition of individual differences by the Australian Government and the egalitarian emphasis of New Zealand; and there also are certain innovations that can be identified, such as:

1. Incentive rewards for voluntary organizations are given by the Australian Government when former Sheltered Workshop participants have remained in open employment for a period of twelve months.
2. Parents and relatives have been trained as primary caregivers—"mental health specialists"—at the Australian Mental Health Association.
3. Community teams have been involved in primary screening of psychiatric patients; and other teams have visited former psychiatric patients who have been relocated in community living arrangments (New Zealand).

Europe

The problems of the care and management of persons with mental disorders confronts all countries and often there is similarity in the broad policies and measures initiated. However, the priorities established at any one time vary with numerous factors that are influenced by culture, politics, economics, precedents, and the like. (May, 1976) In general European psychotherapeutic practices and rehabilitation procedures resemble their American counterparts. (*Gittelman, 1975*) Mental hospitals continue to be the primary housing and therapeutic facility for the psychotic patient, although there is a marked trend toward shorter periods of hospitalization and multi-disciplinary approaches to therapy. Frequently, rehabilitation procedures are incorporated with the therapeutic processes. Partial hospitalization and psychiatric units in general hospitals have been established in several countries and the supportive network of facilities and services are being expanded in the communities. In many European countries, the trend is to joint planning between hospital and community plus positive statements that no more large, self-contained mental hospitals would be constructed.

As in the United States, Europe has manifested heightened attention to vocational rehabilitation but there has been a more inclusive perception that encompasses rehabilitation of the "whole" individual. Work therapy, occupational therapy, ergotherapy, industrial therapy (*Black, 1975*) and vocational rehabilitation are some of the terms used in Europe and in the United States. Each has different shades of meaning and dissimilarity in levels of expected complexity of work accomplishment. However, all of the terms refer to the preparation of an individual to perform some level of work skills in some kind of a work setting. Therefore, an attainable level of self-care and independence level is stressed.

In essence, the European countries demonstrate a great deal of similarity in the framework that outlines their approaches. A further survey of several of the European countries identifies the differences.

Belgium revised its Rehabilitation Act in 1963 so that it provided a comprehensive rehabilitation program with occupational resettlement and social reintegration as goals. The Act applies to all disabled persons regardless of the nature or origin of their handicap or their economic status. Belgians and foreigners are entitled to rehabilitation under this Act. The one significant eligibility requirement is that the individual's handicap must be such that it decreases his capacity for employment by at least twenty percent. Other legislation mandates that specified businesses and the civil service must employ a fixed quota of disabled persons. Medical treatment, vocational guidance and vocational training are part of the rehabilitation program. (*Houssa and Maron, 1980*)

Czechoslovak Socialist Republic differs from most other countries in Europe because its political ideology does not encourage private enterprise with the result that there are very few privately owned businesses. Added to this is the fact that all medical and social care of the citizenry is the state's responsibility and these services are provided free of cost to all citizens. Each catchment area of from 100,000 to 150,000 inhabitants (districts) has a minimum of one department of rehabilitation medicine associated with an out-patient clinic or a hospital. Vocational rehabilitation is provided without cost to all disabled people who have the capacity and wish to work. Sheltered workshops, sheltered working conditions in the Union of Invalids and in the producer cooperatives of invalids are available for the severely handicapped. All workers are represented by the Trade Union which assists in the vocational rehabilitation of disabled persons. The psychiatrially disabled, however, are not served at the district rehabilitation departments. They may be placed in specialized Rehabilitation Institutes. A shortage of trained staff and rehabilitation facilities hampers the Government's efforts to fulfill the needs of all disabled persons. (*Janda and Brazdilova, 1980*)

In 1972, **Denmark** dispensed with private insurance plans and directed governmental financial and other supports to the social and vocational needs of all disabled people. (*Gittelman, 1975*) This included the physically and psychiatrically disabled as well as those who for reasons of social circumstances had been disabled—alcoholics, drug addicts, criminals. In addition, the direction for in-hospital care for the mentally ill favored the use

of the general rather than the specialized psychiatric hospital. Later, in 1976, the Law of Social Assistance merged several legislative measures into one law and introduced the central principle of the "single-string system." This system specified authority for services under one authority originating with the public assistance offices of each local municipality; and county boards were established to administer the pensions previously controlled by the state. The catchment area covering each social service center covered a population of 5,000 to 6,000. The decentralization to twelve regional units sought the establishment of procedures for community involvement in planning, decision-making, managing, counselling, and the like, in accordance with local requirements. Prevention and totality of services for individual and family needs became the two key concepts. Special care services remained primarily the state's responsibility but this, too, was planned for inclusion in the general system of social assistance beginning in 1980. (*Kongerslev, 1980*)

The Danish rehabilitation program (*Kongersley, 1980*) is tripartite in organization and in the phases of program planning. Organizationally, the program coordinates the efforts and expertise derived from social, medical and labor efforts. From the programming aspect, the following steps are accomplished:

Analysis—	personal characteristics (medical diagnosis, etc.), environmental circumstances (family and other milieu) and rehabilitation diagnosis
Programming—	the origination of vocational plans within the framework of the current business and industrial job market
Effectuation—	implementation of the plan

Although the revised Danish rehabilitation system is in its beginning stages, it has established an approach that is responsive to the mentally ill. The National Association for Welfare of the Mentally Handicapped (founded in 1960) is a public welfare association that provides direct assistance to patients and their families with the goal of reinforcing their movement toward self-help efforts. This Association, consisting of professionals, consumers and other interested persons, is subdivided into regional and local bodies that concentrate on the communities' needs. A variety of programs and services are offered, such as: establishment of psycho-social cooperative groups, vocational rehabilitation, ombudsman, financial support for extra-clinical services, advanced interdisciplinary training, and public relations work. In spite of the good intentions expressed in the revised legislation, problems of sufficient staff, particularly of psychologists with clinical experience, training for staff, and high unemployment interfere with full realization of rehabilitation goals for all disabled persons. (*Kongerslev, 1980*)

Social psychiatry is strongly embedded in the ideological foundation of psychiatric practice in **Finland**. The Finish Academy of Science has designated psychiatric disorders as the focus for research in Finland because of its prevalence and disabling effects. The Foundation for Psychiatric Research in Finland sponsors research, particularly with a focus on social psychiatry, and publishes a yearbook "Psychiatria Fennica" as a forum for Finnish and international developments in psychiatry. (*Psychiatria Fennica, 1978b*) The Finnish Association for Mental Health supplements the research efforts of the Psychiatric Association with services such as: Veikkola Occupational Clinic, SOS-service Suicide Prevention Center, and the review "Mielenterveyslehti" and also has regional and local committees engaged in educational, informative and service development activities. Rehabilitation of the mentally disordered and prevention of the occurrence of such disorders are included in the Mental Health Associations advocacy efforts. (*Psychiatria Fennica, 1978a*)

The National Pensions Act is the insurance in Finland that covers all citizens from their sixteenth birthday. This Act provides pensions for persons who are elderly and for those who lack the capacity to work. The Act excludes "aliens" who are members of foreign legations and consulates and individuals with less than five years residency in Finland. For purposes of rehabilitation, the National Pensions Institute provides medical care, education and vocational training. The financial supports and the rehabilitation services are made available to citizens irrespective of whether they previously paid national pension insurance contributions. (*National Pensions Institute, 1969a, 1969b, and Undated*)

France has a long history of famous names associated with psychiatric interests among which are Pinel, Esquirol, Charcot, Sequin, Itard and Binet. Phillipe Pinel has been identified as the liberator of the mental patients from their chains in the eighteenth century. These men and others have contributed to the understanding of mental processes and yet in spite of the many advances during the eighteenth and nineteenth centuries the progress of psychiatric approaches exhibited both waves of favorable and unfavorable characteristics until after World War II when more concerted attention was centered on psychiatric services. (Pichot, 1978) After this War, the French Government sought ways in which to expand and organize mental health services and eventually formulated the sectorization system in 1960. The "sector" policy depends on a mental health team for each specified geographical area with reimbursement from the Government for treatment and/or rehabilitation in accordance with the patient's needs.

Sectorization made mental health services available to all French citizens but the diversity of care among the different sectors made for unevenness in the quality and sometimes the quantity of care. Added to this unevenness is the resistance to establishing vocational rehabilitation services. The roots of this resistance may have originated from the French people's experience with concentration camps during the War when banners were hung with the slogan "Arbeit Macht Frei" (Work creates freedom), or there may be other humanitarian concerns about

lengthening the hospitalization of mentally ill persons if vocational rehabilitation were integrated with other treatment procedures—or perhaps even more significant may be the practical aspect of lack of funds. Rather than vocational rehabilitation, France has stressed social rehabilitation. Thus the concentration on services to maintain the patients with their families was predominant. Supportive home treatment is provided and patients continue in their communities and on their jobs—delaying and even avoiding relocation in distant mental hospitals or in other community facilities. (*Gittelman, 1975*)

Hospitalization for the mentally ill may occur in one of the following: (Pichot, 1978)

"*Placement voluntaire*"—	at the request of the patient's family, with a medical certificate and some other legal controls. The patient's acceptance of this placement is not required.
"*Placement d'office*"—	for dangerous patients, based on legal decisions
"*Placement libre*"—	patient's voluntary hospitalization

Small private psychiatric hospitals or clinics and private psychiatrists have increased considerably. This has caused some concern by the public psychiatrists who anticipate that a new kind of segregation might emerge separating the chronic patients who remain part of the sectorization plan from the more affluent who can afford the extra cost of private psychiatric care. Social security repays only part of hospitalization costs. Half-way houses, rehabilitation workshops, day hospitals and sheltered workshops are among the non-governmental services offered. The problem that emerges is that the numerous voluntary agencies added to the governmental organizations create coordination difficulties as well as duplication and fragmentation of services. (*Carnes, 1979*)

France's sectorization scheme bears the positive elements of a public recognition of the rights to services for all French people. However, in its orientation to community autonomy with perhaps insufficient guidelines on a national level, it has lent itself to proliferation of programs and fractionated rehabilitation.

The conditions for the development of psychiatric services in **Germany** were exceedingly difficult during and after World War II. It was not until the 1950's with the origin of the *Federal Republic of Germany* that concern with psychiatric services was revived. The endogenous source of mental disorders is stressed and psychiatrists are perceived as "fatherly teachers." (*Townsend, 1978*) Such views affect the therapeutic and rehabilitative processes as well as the behavior of the patients. Acceptance and direction by others at home, at work and in the hospital become the most important factors in therapy/rehabilitation. (*Vogel and Vligen, 1975*) Added to these perceptions is the inclination to view mental disorders as incurable because of the frequently emphasized biological origins.

At the Governmental level rehabilitation efforts are based on an interrelated assortment of six legislative schemes. These are: (*Gemsjager, 1978*)

- National Health Insurance Scheme
- Disablement and Retirement Insurance Scheme
- Industrial Injury Insurance Scheme
- Federal Institute of Employment
- War Veterans and War Victims Assistance Scheme
- Social Assistance Scheme

In general, the disabled person remains the responsibility of the rehabilitation agency until he or she is fully reintegrated. Yet, the restriction on the application of the Social Assistance Act sometimes hinders the provision of full services since this Act can be administered only when there are no other rehabilitation service agencies or relatives to assume responsibility. In 1974, the Act for Standardization of Rehabilitation Services was enacted assuring the availability of procedures for obtaining services in situations of urgency. This Act also obligates all rehabilitation authorities to cooperate in implementing an integrated rehabilitation plan.

A directorate serving as a coordinating body is established at the national level, and voluntary organizations complement the government efforts directed toward rehabilitation. For future planning, the Government seeks to concentrate on the establishment—with the help of families—of independent commercial enterprises (workshops) for local production rather than general factory work or sheltered workshops. (*Gemsjager, 1978*) Furthermore, the German Society for Social Psychiatry focuses on public welfare and works towards the progress of psychiatric therapy and rehabilitation.

Several innovative procedures have been established by the Federal Republic of Germany. These are directed to the early intervention and rehabilitation of the mentally ill and also have relevance for mental health of the non-psychiatric population. Some examples of these programs are as follows: (*ILO, 1979*)

- Psychiatric care available through the firms medical service at the place of employment—Badische Anilin Und Soda Fabrik (BASF)
- English courses for mentally restored persons (primarily schizophrenic); and a treatment/rehabilitation plan that serves as an instrument and motivation for social learning—Mannheim Central Institute for Mental Health

- Early intervention emphasizing the continuance of community social and vocational contacts by mentally ill persons—Research Centre of Stifung Rehabilitation
- Early onset of integrated training for the mentally ill supported through interdisciplinary teams and group dynamic procedures—The South-West German Rehabilitation Centre for Children and Young Persons
- Comprehensive network of services for rehabilitation of the long-term mentally ill—Psycho-Social Working Group, Heidelberg-Mannheim

The devastation of continuous wars in **Greece** has resulted in a large number of disabled persons. Growing industrialization also has imposed stresses that have increased the emotional disturbances of the Greek people. Yet, in spite of the problems of war, the numerous earthquakes, and industrialization, Greece remains predominantly an agricultural and rural country with the family caring for their relatives, the church as a source of comfort, and the local authorities responsible for the inhabitants of the community. After World War II, the rehabilitation program became more entrenched in the governmental efforts under the Ministry of Social Services.

For adults, rehabilitation services are the responsibility of private clinics, special orthopedic and rehabilitation hospitals, and the National Fund for Rehabilitation of the Disabled. Vocational training is included in the National Fund's program. Future plans focus on the creation of several small rehabilitation units in selected cities through the coordinated efforts of certain Ministries and voluntary organizations. (*Karantonic and Diamandidou, 1980*)

The Center for Mental Health was established in 1956. It is a non-profit organization subsidized by the state and as of 1975 operated the following services: (*Center for Mental Health, 1975*).

	CITIES		
SERVICES	Athens	Piraeus	Solonica
Child Guidance Clinics	X	X	X
Social Psychiatry Services	X	X	X
Psychotherapy Unit	X		
Educational Programs	X		
"Stoupathion" School for Mentally Retarded Children	X		

The Social Psychiatry Services for adolescents and adults include: therapy, day care units with occupational therapy and therapeutic clubs, and community action to spread mental health principles and encourage coordination of activities of existing agencies in the field of mental health.

Alterations in the institutional systems of **Italy** originated at about the same time—in the late 1960's— as women's liberation and other minority efforts sought civil rights. (*Basaglia, et al, 1979*) Added to these protests were the students' and workers' revolts that inspired a general feeling against institutions that included mental hospitals. An anti-institutional struggle began and a "democratic psychiatry" with social integration for the mentally ill became the central goal. These struggles and changes in mental health services are exemplified in Trieste, a province in the extreme north-east corner of Italy. Before World War I Trieste was a part of the Austro-Hungarian Empire. (*Bennett, 1978*)

A law was passed in 1968 which introduced voluntary treatment and a more suitable staff/patient ratio in mental hospitals. A few years later a policy was initiated for phasing out the Trieste Mental Hospital and substituting other services in the community. Slowly, then more rapidly, the number of patients discharged increased. Sectorization of hospital wards, of catchment areas, of the staff by teams ensured the flow of services so that these would be geographically accessible for the population outside of the hospital. Methods of care were revised for those patients who continued in the hospital with staff members from the newly created district mental health centers in constant contact with the patients. Compulsory commitments were reduced and voluntary admissions encouraged. A social security allowance for discharged patients was initiated; and ergotherapy was discontinued and replaced by worker's cooperatives with salaries paid to the employed former patients. (*Bennett, 1978*)

To offset the closing of wards and to provide for the discharging of patients into the community, the following actions were taken: (*Bennett, 1978*)

- 1974 — 3 district mental health centers
- 1976 — 2 additional mental health centers
- 1976 — group apartments for discharged patients
  By 1978, there were 18 group apartments with a total of 80 residents
- 1977 — the final district mental health center

Later, a special admission unit at the Trieste Hospital was turned over to a separate staff for overnight stays of acutely mentally ill patients. This unit was independent of the other parts of the hospital and was associated with the district mental health centers. The General Hospital also became part of the system providing consultation and emergency services.

In these deinstitutionalization proceedings, staff and patients moved to the community with the closure of the hospital wards with no interruption of services or staff responsibility. In other words, "staff and patients were deinstitutionalized together." (*Bennett, 1978*) Rather than emphasizing formal psychiatric care, this service provided a supportive as distinguished from a medical orientation. A new health law of 1978 was designed to strengthen links between all parts of this comprehensive continuity of services.

Rehabilitation of the mentally ill is dispersed among numerous voluntary societies in the **Netherlands** with the consequence that coordination is an unwieldy problem. Religious organizations, such as the Protestant and the Roman Catholic Foundations and other voluntary non-sectarian organizations have assumed the predominant roles in rehabilitation efforts. (*Gittelman, 1975; Carnes, 1979*) Several coordinating agencies have endeavored to harmonize procedures. These agencies include: Netherlands Central Society for the Care of the Disabled, the Central Council of Rehabilitation (combined into Netherlands Society for Rehabilitation) and beginning in the late 1960's a governmental agency, the Interministerial Steering Committee on Rehabilitation Policy. The states are responsible for the planning, organizing and financing; and denominational foundations and non-sectarian groups provide services.

The Employment Service (ES), a national agency, is charged with job placement of both disabled and non-disabled persons; and a special division of ES arranges for vocational rehabilitation. Specialized staff in most ES offices handle the physically and mentally disabled with other specialized staff for blind persons. Almost all hospitals have work therapy programs and many of the large cities maintain rehabilitation workshops—"social workshops"—with contract work from private industry for which patients are usually paid on a piecework basis. Legislation requires industry to employ a three percent quota of rehabilitated disabled persons but the government does not enforce the regulation.

The Social Employment Act mandates that all communities provide sheltered employment for disabled persons capable of productive work—if they wish to participate. There were about 180 sheltered workshops* in the Netherlands employing (as of 1975)—41% physically handicapped, 29% mentally handicapped, 15% mentally ill and 12% neither ill nor handicapped. (*Hardeman, 1975*) In some regions, there are special workshops for the mentally handicapped or for the mentally ill. The staff of these workshops are recruited primarily from craftsmen with technical school diplomas who are not specifically trained in working with the mentally or physically handicapped. A few of the staff members have been occupational therapists or were trained as psychiatric nurses. (*Hardeman, 1975*) Although the Social Employment Act emphasizes the purpose of sheltered employment as vocational rehabilitation, these workshops have been criticized for lack of client turnover. (*Carnes, 1979*) However, some creative approaches to reintegration are evident. For example, a socio-vocational pilot project to provide vocational rehabilitation for mentally restored persons isolated in the community has been in existence for a few years. This program is administered through the combined efforts of the medical service of the factory association and other professional groups with the cooperation of the Dutch Ministry of Social Affairs, the Employment Service staff members and local authorities—Joint Medical Service of Personnel Associations. (*ILO, 1979*)

* ILO reports approximately 200 sheltered workshops (ILO, 1979)

The principles of the Social Psychiatric Service underscore the progressive community-oriented approaches of the Netherlands. Concerted efforts are expended in averting hospitalizaiton through such means as 24-hour crisis intervention centers that exist in most large communities. The Sick Fund, a national health insurance, covers payments for most of the psychiatric and rehabilitative services. Innovative community-oriented programs have been initiated for the mentally ill and the mentally restored, such as: (*ILO, 1979*).

- a comprehensive network of community services for psychiatrically disabled persons that includes observation, day care and psychiatric centers, a rehabilitative/training workshop, a teaching agency, evening course programs, and a hostel — Schroeder-van-der-Kolk Association.
- community-based socio-psychiatric services of the Community Health Service Centers to provide a continuous flow from the hospitals, out-patient centers and private medicine with resettlement services — Public Health Service, Community Mental Health Department.

If hospitalization is deemed essential, the tendency is to locate the mentally ill person in an out-patient clinic, general hospital, or psychiatric hospital nearest the patient's community of origin. The difficulty arises about the patient's release from the mental hospital. Even though the Netherlands have an effective system to prevent hospitalization, barriers hinder the patient's return to the community. The rigidity of release procedures based on work competence criteria do not permit a gradual step process. (*Gittleman, 1975*)

The benefits available to the mentally ill persons are generous by U.S. standards but at least two negative aspects are identifiable. Difficulties emerge from the fee scales and the kinds of coverage permitted. (*Gittleman, 1975*) Secondly, the benefits may actually impair motivation for renewed employment at the same time they were making the life of a disabled individual more satisfying and meaningful. (*Carnes, 1979*)

Norway has a strong democratic tradition within a kingdom form of government. It is a large country with the smallest population density in Europe, subjected to a severe climate and surrounded by massive mountains and limited tillable soil. There is a history of folk remedies and widespread beliefs of magical powers that supposedly evoked diseases as well as mental disorders. Today the majority of the population is homogeneous in its ethnic and religious roots and industrialization has made many improvements possible but has increased the number of stressors (*Eitinger and Retterstøl, 1977*).

Nineteen mental hospitals are available for psychiatric patients who require in-patient treatment. However, the trend is away from hospitalization to community-based facilities such as day care, out-patient clinics, or the psychiatric departments in one of the 23 general hospitals.

The Director of Mental Health Services in Norway* supervises the quality of mental health services including services to the retarded, epileptics and special programs for alcoholics and drug addicts; and establishes guidelines for the planning, organization,

* The discussion that follows is derived from Dr. Steefeldt-Foss' article of 1979 except where otherwise indicated.

and operation of services on behalf of the Ministry of Health and Social Affairs. The applicable legislation that regulates mental health services are as follows: Mental Health Act of 1961, Hospitals Act of 1969, National Health Insurance and Disability Pensions Act of 1966 and the Social Care Act of 1964. The Act on Primary Health Services intended to be passed by Parliament in 1980 provides Norway with a composite legal mechanism for securing a coordinated total care service system. When this 1980 law is enacted the Mental Health Act may be discontinued as a special act. Certain regulations from the later Act would be retained in the General Hospitals Act and the Act on Primary Health Services thus maintaining directives pertaining to civil rights and the legal security of the patients in all types of institutions.

The direct planning, establishing and operation of mental health services is conducted by the counties and presented for approval by the Ministry of Health and Social Affairs through the King in Council. These plans must reflect the principal of the "lowest effective level of care." Private organizations whose programs have been integrated into the county's comprehensive plan implement the proposed services. A 50/50 state and county formula provides the funds after the foregoing steps have been completed. From 1980 on, a decentralized system will delegate the distribution of funds from the state to the county without "detailed steering" from the Ministry. Services are to be reorganized to form a comprehensive community service system with continuity of care. The county institutions will have the responsibility to incorporate the mental helath services in the planning for a defined geographic catchment area. The following five essential components are to be included:

> in-patient services, out-patient services, partial hospitalization, emergency services, and consultation/education to community agencies and professional staff . . . (and) rehabilitation and pre-and after-care services including foster-home placements and half-way houses, training, research and evaluation.

Norway has become convinced that the psychiatric disorders must be allotted priority in the health scheme of services. This conviction has been supported by the findings of a recent epidemiological survey which identified the following:

- Psychiatric disorders account for 30% of all disability pensions as compared with approximately 15% for diseases of the joints and muscles and cardiovascular diseases.
- On any one day, more than 30% of the 56,000 patients institutionalized were mental patients.
- The life-time disability expectancy of psychosis is 5.5% for women and 5.2% for men. The incidence of schizophrenia is less than 1%. However, these figures of the incidence of schizophrenia may not be comparable with other countries since the diagnosis of schizophrenia is more restricted in Norway.
- In general practice, 25% of all diagnoses are psychiatric with neuroses and psychosomatic disorders making up the largest portion of this percentage.
- The suicide rate in Norway is lower than in other countries — 9 completed suicides per 100,000 annually compared to 20 per 100,000 in other Scandinavian countries.

Rehabilitation services (*Lereim, 1980*) in Norway are the responsibility of a number of organizations, such as: State Labor Exchanges, State Rehabilitation Institutions, socio-medical departments in hospitals, schools, sheltered workshops, private industry, and public employment. Each county medical office has a counselor required to maintain contact between governmental departments and voluntary organizations. Since a social-psychiatric view influences all mental health services, rehabilitation is conceived as more than vocationally oriented but instead related to all aspects of a "normal" community life. As a consequence of this ideology many services are incorporated into the process of rehabilitation, such as transportation, recreation and other social opportunities. In addition, there is a new law proposed that will focus on the work environment and the opportunity for conselors in the working site who would be made available to all workers.

Norway is aware that there are numerous problems confronting the country that are not easily resolved. Service and staffing shortages persist and more complete and accurate information-gathering must be established. However, the positive approach to seeking solutions plus Norway's intent to move toward mental health care as part of primary health care and social services bodes favorably for the problem of mental disorders.

Psychiatric care in **Poland** has a long tradition originating with religious institutions and the first "family care" system established in 1880 in a village in the Vilno district. After World War I care centers were set up in association with several psychiatric hospitals so that just before the second World War 3,000 mental patients were located in colonies or with foster families. Farm work, organized social life and milieu therapy became part of these extramural care centers. (*Puzek, Undated*)

In 1944, after liberation, the People's Republic of Poland sought to develop services for the rehabilitation of disabled citizens but were hampered by lack of technical knowledge and professional personnel. As rehabilitation services were gradually accomplished, the war disabled were addressed first and later services were extended to other disabled individuals including the mentally ill. (*Kempinski, 1980*)

The responsibility for rehabilitation is delegated by the Decision of the Presidium of the Government to the Ministry of Health and Social Welfare. This Ministry is the coordinator of rehabilitation services; and the fact that vocational rehabilitation and employment of the disabled are integrated with health services reflects the government's view of the problems of the disabled as a complex constellation of more than work-related concerns. In addition to the Ministry, the Central Board of Trade Unions is mandated to collaborate with health instituitions and to develop rehabilitation services.

Disability certification is required and individuals are assigned to one of three levels of disability depending on the assessed severity of the disability. These levels range from those persons unable to perform any kind of work and who require permanent care from another person, to the second group of persons with limited work capacity but who can function without the permanent care of another person, and the third group of persons capable of self-care yet unable to resume their former employment and requiring retraining in another type of work. (*Kempinski, 1980*).

Rehabilitation of patients in mental hospitals includes pharmacological treatment, physical exercises, occupational therapy and work activities that prepare the patients for employment. However, several factors hamper the inclusion of many patients in the rehabilitation system, such as: overcrowded hospitals, lack of a sufficient number of skilled personnel, too few workshops, and the lack of raw materials. Rehabilitation services that have been incorporated in the out-patient settings in the community also need to be expanded. (*Hulek, 1972*) Poland has recognized the importance of rehabilitation in the restoration of the patient's living and working skills. In fact, rehabilitation has been included as a medical speciality with degrees offered in this field. The general practice is for all members of a rehabilitation team to annually update their knowledge and skills in postgraduate education.

Another view was expressed by Jankowski, et al (1976) who questioned the success of psychiatry with the "so-called schizophrenic." Because these clinicians believed that psychotherapy was not enough, they planned a project that would utilize a whole range of assistance aimed at satisfying various needs — social help in the broad sense. Their project was directed to be an effective, replicable, and economic system based mainly on psycho-social precepts. Their center "Synapsis" at the Warsaw Mental Health Unit concentrated on the whole family. The Greek word "synapsis" was adopted because its meaning, "joint, contact, junction," represented the objective of person-to-person interactions in joint efforts towards learning and development. The pattern of group relationships merged several communication procedures such as: discussion of symptoms, emotional expression, reactions to crises revealed, and role playing. The essential strategy of the "Synapsis" technique relied on the dialogue about symptoms in a socially acceptant climate rather than masking symptoms with excessive neuroleptics. An Ex-Patient Club was started in Lomiani on a non-professional model but it was closed because of some unfavorable results and its costs were too high. All efforts of Synapsis focus on the symptoms, on the crisis, on the emotional reactions. Rather than covering up these behaviors with excessive neuroleptics, there is an effort to conduct a dialogue about them. Other activities have been added to the original group such as: hostels with communal living, a new club and camps. Assessment of the efficacy of the project's procedures are ongoing.

Portugal views rehabilitation as a coordinated constellation of services including the following: medical, educational, psychosocial and socio-professional; and includes physical and mental disabilities in its rehabilitation service system. Despite a broad definition of rehabilitation at the national level, dissimilar criteria of eligibility, scope of services and approaches emerge from the administrative decisions of the institutions. As a consequence, the availability of services and the range of effectiveness tends to be contingent on bureaucratic formalities. There has been a movement to establish a more uniform and coordinated system that has been given momentum since the revolution in 1974. The new Constitution of the Portuguese Republic supports the centrality of rehabilitation by the implications from its section that ensures the rights of physically and mentally handicapped persons. (*Santana-Carlos, and Castelo-Branco, 1980*)

Romania's mental health system is characterized by regional planning, regional placement of patients, detailed case records and follow-up procedures. Care for mentally disturbed individuals can be initiated early while the person remains employed on a part-time basis. A psychiatrist can prescribe shortened hours per week and the patient remains on full salary. Treatment in mental hospitals has been de-emphasized and the focus of care has changed to day hospitals and psychiatric departments in general hospitals. Work-oriented rehabilitation is accomplished by means of vocational retraining and sheltered workshops and re-socialization procedures are added to these measures. (*Gittleman, 1975*)

An innovative hospital program is described in Madrid, **Spain** by Belda (1976) that involves the mental patient in work therapy at the earliest possible time. This work therapy is not just a time-filler or form of entertainment but must have meaning for the worker and also must produce a marketable product. Added to these criteria is the requirement that the worker must be paid for working. The psychiatric hospital described by Belda has no fences and no locks. The dignity of the patient is preserved. Patient workers and staff are formed into an "artisan cooperative" which functions independently of the hospital with its own governing Council for planning and administration. Work is allocated to patients on the basis of their interests and skill development rather than diagnoses or psychological tests. The hospital population has been reduced considerably by permitting the patients to have "long paroles" that permit them to become gradually reintegrated into their family and the community without concern for a lack of support from the hospital when needed.

Sweden's social system is similar to that of the United States but differences can be noted in Sweden's health care and welfare systems that place greater emphasis on ensuring social security and the quality of life for each citizen. (Dencker, 1980) The treatment and rehabilitation of the chronic mental patient has been given a great deal of attention with recommendations, such as: abolishment of traditional psychiatric hospitals leading to decentralization or perhaps the modification of traditional hospitals in some form so that the hospitals may be retained. Dencker (1980) suggests that a compromise between these diverse viewpoints might be the best solution. These proposals have existed for several years, and in fact, the advocates of the phasing-out of hospitals expected them to be eliminated by 1980. (*Gittleman, 1975*) However, the large psychiatric hospitals continue, usually with a reduced population, and some have integrated community-oriented rehabilitative procedures with their in-patient service system.

Dencker (1980) describes an integrated psycho-social rehabilitation program in one of the departments of the Lillhagen Hospital, Goteberg, Sweden. This Department has 234 beds with two day-care wards and a day-center in the nearby city of Gothenburg. The following summarizes the treatment/rehabilitation process that concentrates on the rehabilitation of chronic schizophrenic patients:

Phase 1 — Admission process — Observation of patient for one or two weeks for diagnostic purposes — Omission of treatment procedures during this introductory period. Neuroleptic treatment is begun after the diagnosis has been completed and this treatment is continued throughout the process of rehabilitation and after discharge.

Phase 2 — Rehabilitation — Begun early when the "bizarre behavior" or the schizophrenic symptoms have abated and thus become more controlled. As a transitional measure, the day patient ward provides day or night treatment or 24-hour treatment as needed by the patient. The rehabilitative process incorporated activities for daily living (ADL) within a structured and integrated community-oriented program with practical, "real" tasks experienced by the patients.

Phase 3 — Discharge — Patients assisted in housing arrangement, employment (as needed), leisure activities. After-care offers the availability of active support therapy at the day-patient unit on the hospital grounds or the day-center in the city. An open-door policy permits the patient to occasionally visit the hospital ward or to return for a "new course in rehabilitation" if social regression ("social breakdown syndrome") occurs. Rather than a political expedient espousing hospital depopulation, the prime consideration for discharge is the patient's psycho-social reintegration. Furthermore, the Lillhagen project stipulates that the in-patient and out-patient staff communicate and coordinate their efforts to structure the hospital's treatment/rehabilitation as part of the components of a comprehensive community-oriented continuity of care. Dencker (1980) suggests that the Lillhagen Hospital project satisfies this latter principle.

Rost (1980) describes another hospital associated rehabilitation program at a regional hospital in Orebro, Sweden. Teamwork is emphasized at this Psychiatric Rehabilitation Department of the hospital and this is extended to the combination of hospital efforts with county employment offices, trade unions, housing boards and charitable organizations. The treatment/rehabilitation program synthesizes the patient's personal needs with assistance in environmental stresses emerging from problems such as income, work, housing or family conflicts. Individualized goals provide the framework for rehabilitation.

The significant contributions from Sweden have been their accent on the psychiatric patient's active involvement in the treatment/rehabilitation process and a commitment to community (social) psychiatry. The social psychiatric view stresses an eclectic approach that gradually assists the psychiatric patient to accomplish objectives that are individualized. "Total care" is the salient point and this care encompasses a variety of measures directed toward the systematic development of mental, emotional, somatic, and social capacities. (*Department of Psychiatric Rehabiliation, 1976*)

Governmental assistance also is directed to community integration of the psychiatrically disabled as well as of other disabled groups. The provision of housing for former mental patients, the mentally retarded and older people is encouraged by Sweden's tax credits and state grants are given to industries that have sheltered workshops or that hire mental patients. In addition, a special state grant provides funds for cultural activities for the disabled. This includes leisure activities as well as libraries for the blind, study consultants, interpreters for the deaf and easy-readers for mentally retarded persons. Voluntary organizations, many exclusively composed of handicapped individuals, supplement the delivery of services of the government. The state subsidizes some of the voluntary organization's expenses but funding is obtained to a greater extent from the general public. (*Ljunggren and Montan, 1980*)

Coordination of the many aspects of treatment/rehabilitation is a complex process. Although the administration of social insurance, manpower services and socio-economic planning is the responsibility of the Parliament and Government, the direct operation of the various services is vested with 23 counties and 279 municipalities. Since the counties are responsible for health care and institutional vocational rehabilitation and the municipalities are responsible for social welfare, coordination of social, medical and rehabilitation services present a problem. A procedure is under consideration whereby a central authority in each community would coordinate the various services. (*Ljunggren and Montan, 1980; Gittleman, 1975*)

Two innovative work-oriented programs are of particular interest for the mentally restored person. These are (*ILO, 1979*):

- *Social-vocational skill training*
  AMU-Centre, Vocational Training Centre, Skovde, Sweden — in a separate vocational rehabilitation setting in the hospital patients are provided with an extensive 20 weeks of training in social and work coping skills after which they proceed to an accelerated training program at a vocational training center. During this latter training period patients live together in small households.

- *Semi-sheltered employment*
  National Labour Market Board, Vocational Rehabilitation Division — Governmental grants are provided for private enterprises who arrange for the employment of physically and mentally disabled persons in their enterprise that also employs non-disabled persons. This arrangement permits non-fully productive disabled to gradually adapt to the work world in a "normal employment facility."

In spite of the progressive liberalism of Sweden, problems exist in several areas besides the coordination mentioned previously. Barriers to employment continue and devaluational attitudes toward the disabled persist.

Tangible, material things are emphasized in rehabilitation more than psychological support and the quality of life. Personnel shortages remain in all professional areas. Carnes (1979) mentions these concerns among others but concludes his remarks with:

> *. . . there is the nagging concern whether or not any comparisons based upon such contrasting social philosophies (as the U.S. and Sweden) possess any relevance at all.*

The core of rehabilitation services in **Switzerland** is its Federal Disability Insurance Act of 1960 which is universal and compulsory. This Act mandates the provision of rehabilitation programs for all persons from birth with physical or mental disabilities; and also provides:

- *Pensions* — for persons 18 years-of-age or older; for persons 65 years-of-age or older — old age pensions
- *Subsidies to institutions* offering services to disabled persons for the construction, establishment, renovation and maintenance of the programs of the institutions and workshops
- *Subsidies to private assistance agencies* serving the disabled

Under the rehabiliation plan the disabled person may obtain medical benefits, vocational guidance, initial training or retraining and job training or capital aid for self-employment and, in addition, special school benefits and subsidies are available for disabled young persons. The Federal Office of Social Insurance is responsible for implementing the plan of rehabilitation drawing from many sources the needed services. Self-help and other voluntary groups perform some of the necessary training.

Four countries make up the **United Kingdom** —Scotland, Northern Ireland, Wales and England. The largest population exists in **England** and this country is the focus of the discussion of rehabilitation for the mentally ill. Even today there appears to be a negative connotation to the label of mental illness — more than in the United States. (*Hawkins, 1977*) This attitude persists in spite of the governmental efforts to establish improved mental health services and may be one of the factors that has deterred full realization of the community needs of the psychiatrically disabled. In the eighteenth century, the mentally ill were cared for in their communities (parishes), in workhouses, poorhouses and jails. Bethlem Hospital in London institutionalized "public charges" — people who were exhibiting acute forms of mental disorders and private madhouses were available for those with financial resources. Others considered "simple lunatics" were hidden in a corner of the house or in a deserted place and were restrained by chains or strong rope. The nineteenth century brought about some reforms in the treatment of the mentally ill with "moral treatment" endorsed as the first form of psychotherapy. Local authorities influenced and supported the erection of mental hospitals outside the cities and the patients admitted to these hospitals were isolated from their families, their communities and the "normal" flow of society. The "less deserving" mentally ill (the poor and/or unemployed) were sent to workhouses. They were considered less curable than those who were institutionalized in the mental hospitals. (*Carter, 1977*)

Throughout these years and even to some extent in the present, the prevailing notion has been that mental illness was irreversible. More and larger hospitals were constructed so that the mental patient might be segregated from the general population. However, World War II and the war-induced mental disturbances led to an increased examination of England's mental health system. There had been previous assessments and legislation but one of the significant turning points occurred with the National Health Service (NHS) Act in 1948. (*Miller, 1979*) The history of mental health care and the dual system of mental health services may have induced the regulations incorporated in NHS to the effect that mental hospitals were part of the health system. Thus the mental hospitals were brought under the control of the state and were assigned equal rights, status and financial support under the law. The Mental Health Act of 1959 further legitimized the status of mental health services and went one step further — community-based services were made the focus of care for the psychiatrically disabled.

Community-based mental health services have been in existence in England for a longer period of time than in the United States. Many documents have been written about ways in which these services can be improved so that the community needs of the psychiatrically disabled might be more fully realized. An examination of the current rehabilitation programs in England identifies the following services for psychiatrically disabled persons: (*Reagles, 1980; ILO, 1979; Carnes, 1979*)

- Employment Rehabilitation Centres (ERC's) — are the responsibility of the Employment Service Agency of the Manpower Services Commission. These are residential centers that provide courses for physically and mentally disabled persons to prepare for work by restoring their self-confidence and motivation and helping them compensate for deficiencies.

- Local authority day centers — are intended to be adult training centers for the psychiatrically disabled. They include a large number of the mentally handicapped (term used for mentally retarded in England).
- Disablement Resettlement Service — is the link between day centers, psychiatric hospitals or other units. Disablement Resettlement Officers (DRO's) assist these psychiatric agencies in determining the patient's readiness to profit from employment rehabilitation programs and vocational courses; and also coordinate the arrangements for services after the patient's discharge. The DRO is an experienced employment officer (recently renamed "Employment Advisor") who is carefully selected and receives ten weeks of specialized training at the National Training Center, Leeds, England. DRO's have been compared in their role and functions with rehabilitation counselors* or the newly emerging "case managers" of the U.S. community support model.
- Industrial Therapy Organizations (ITO's) — provide sheltered work experience (work activity) with an average training period of six months. Some of the ITO's emphasize activities directed to higher-level training or subsequent employment. Occupational therapy, vocational evaluation, and the like are some of the services offered.
- Local authority Rehabilitation and Assessment Centers (LARAC's) — provide pre-vocational and job skill assessment, sheltered work, situational assessment and job placement through Manpower Services.
- Employment Rehabilitation Centers — provide courses of six to eight weeks in length with emphasis on establishing work information and filling in gaps in knowledge and skills needed for employment.
- Industrialization Rehabilitation Units (IRU's) — for disabled people to undertake a limited time program of pre-vocational exploration and evaluation under the supervision of an inter-disciplinary team. These IRU's are maintained by the Department of Employment and serve certain categories of the non-disabled as well as the disabled, including the psychiatrically disabled. Remploy is the national system of sheltered workshops, financed by the Department, that provides employment for psychiatrically and other disabled persons who are not suitable or not yet ready for competitive employment.
- Sheltered Industrial Groups — Psychiatrically disabled persons are employed in selected work locations in open industry with the regular labor force. The disabled workers continue to receive shelter and other support services. This work arrangement does not penalize the psychiatrically disabled who produce at lower levels than other non-disabled workers and also serves to extend the variety and type of work available with potential transition to competitive employment. "Projects With Industry" in the U.S. is similar to this work arrangement.

Psychiatric hospitals provide the largest number of residential accommodations for the mentally ill. A large proportion of these persons are elderly and do not want to leave. Community residential living arrangements take the form of group homes, foster care and hostels. Social club programs such as Brindle House in the Manchester area provide programs for former patients.

There are many innovative approaches that have been introduced in England. Some of these are, as follows: (*MIND,** *1977*) A rehabilitation unit has been developed at Knowle Hospital in Southampton. This unit is directed to enclaves of the long-stay patients with a carefully designed program operated by a multi-disciplinary team. The plan includes improved ward surroundings, personal space and personal appearance; a work program including occupational therapy in the evenings; and procedures for stimulating interest in the outside world. Twice weekly community meetings of all staff and all patients focus on establishing interpersonal relationships, reality-orientation and opportunity to discuss thoughts and feelings. Families are counselled with the patients to identify problems and discover ways to cope with them. Programs emerging from community based efforts are exemplified in the following: (*MIND, 1977*)

- The East Birmingham Community Health Council involved trade unions in the examination and development of methods for resettling mentally handicapped people into employment.
- The Peter Bedford Project in London emphasizes respect for the individual and individual responsibility. This Project provides work and training opportunities as well as living arrangements for disabled people during their period of training or when they are working.
- The Richmond Fellowship was organized two months before the Mental Health Act of 1959. Housing programs along the model of a therapeutic community have originated in England, Australia, New Zealand, Austria and in the United States.

The gaps in services for the rehabilitation of the mentally ill are so similar to some of the problems in the United States that it is difficult to avoid comparisons. More needs to be done. The progress planned and sought in the 1971 Mental Handicap White Paper and the 1975 White Paper on "Better Services for the Mentally Ill" have not met expectations. Added to these White Papers is the Government's Housing Policy Green Paper of 1977 that recognized the importance of housing for the mentally ill returned to the community and also for the mentally handicapped. Voluntary organizations, such as the Mental After-Care Association, have endeavored to provide hostels, cluster flats or group

* The occupational psychologist in England seems to be more similar to the professional training and the role of the rehabilitation counselor in the U.S.

* MIND is a "national mental health charity" concerned with the provision of needs and rights of the mentally ill and the mentally handicapped persons. It is part of the National Association of Mental Health and has local subdivisions.

homes. More rehabilitation centers as well as more jobs are needed for the psychiatrically disabled. Courses and training that have been based on the model planned for the physically disabled may have to be revised and the time involved for training and/or education may have to be lengthened. The definition and funding for medical, social and vocational services need to be coordinated so that discontinuity of services and duplication may be avoided. The potential disincentive to employment prompted by the policies for obtaining financial benefits should be altered. The governmental cuts in public expenditure in 1979 were particularly disadvantageous to the psychiatrically disabled in the community. The aforementioned are some of the concerns expressed by professionals, voluntary associations, and the Government.

"Prophylactic" public health is discussed as one of the most important aspects of medicine in the **Union of Soviet Socialist Republics** and the process of rehabilitation aids in this goal of prevention. Work therapy is introduced as early as possible for the hospitalized patient to combat any disabling effects of psychiatric problems and to hasten the process of return to the community. The sociopolitical and economic ideology of the USSR affect the practice of psychiatry particularly since private psychiatrists do not exist. (*Gantt, 1973*) USSR rehabilitation (*Kabonov, 1973*) focuses on resocialization — the restoration of the individual's feelings of social worth. The basic principle is that the rehabiliation process requires a partnership of cooperative efforts in which the patient must actively participate in the various aspects of re-establishing and improving psychological, social, familial, and occupational functioning. This usually entails restructuring the patient's attitudes and coping skills while compensating for any residual disabilities. The predominant precepts would be: "when a person falls ill, he falls ill within society and any cure of a mental illness must take place within society" — the struggle is "*for* the person and not *against* the illness."

In esssence rehabilitation and therapy are a single process conceived as clinicobiological, social and environmental problems. Each stage of the therapeutic/rehabilitative process is planned in steps with gradual transitions selected from: psychopharmacology, occupational therapy, job placement, day and night dispensaries, weekend hospitals, hostels, clubs, camping and the like. Group methods (Volovik and Vid, 1973) have concentrated on the therapeutic influence on the collective and have stressed cultural therapy and especially occupational therapy. There has been an avoidance of the group approaches of foreign origin emerging from psychoanalysis, psycho-dynamics and existentialism. Therapeutic physical exercise, games, free and partially structured dialogue improvisation, narration and later discussion of brief parts of fiction, and so on, encourage the activating techniques preferred in the USSR.

The V.M. Bechterev Lenigrad Psychoneurological Research Institute founded in 1908 is known as a research center and higher educational institution. It also publishes volumes of scientific articles and provides consultation to the medical practitioners who refer patients to the scientists specializing in clinical medicine. The Institute conducts a variety of clinical, psychological and morphological investigations and incorporates the methods of neurocybernetics, information theory and mathematical statistics in its research. As of 1967 (Ministry of Health, 1967), there were three groups of research departments: the clinical departments, diagnostic and treatment departments (without clinics) and the laboratory-experimental department. The clinical department concentrates on studies such as: the experimental therapy of psychoses, clinico-psychological and socio-psychological fundamentals of rehabilitation, therapy and social readaption of psychiatric patients and other specialized areas.

A system of psychoneurological dispensaries were established that maintain contact with various agencies serving the psychiatrically disabled. These dispensaries provide residential services. Mobile emergency psychiatric services are available in many areas. District psychiatrists at industrial enterprises send workers in need of treatment/rehabilitation to sanatoriums and/or arrange for another job if desirable. Thus the psychiatrist is the link between the administration and the worker. In addition, psychiatrists educate the workers about prevention and treatment and assist their families. (*Serebryakova, 1965; Allen, 1973.*)

It is difficult to present a complete or even an accurate picture of rehabilitation of the mentally ill in the USSR since the descriptions that were made available were dated 1965, 1967, and 1973. More recent articles report some serious concerns about the treatment of the physically handicapped, (*Kiselev, 21979, Ginsburg, 1979*) and the misuse of the psychiatric diagnosis. Health services for the general public, however, are discussed in a recent article by the Minister of Health of USSR (*Petrovskij, 1979*) pointing out that every inhabitant of the Soviet Union has access to the "very best of medical care" because of the Soviet health plan. Health services are distributed according to an organization whereby the USSR is divided into administrative areas called "rayons" and these in turn are subdivided into medical districts (ucastoks) of approximately equal population. A doctor and a middle-grade medical worker (feldsher) is assigned to each medical district. Poly-clinics have become large diagnostic and treatment centers with continuity of health services between all curative and preventive services. Though problems may exist they are not apparent in this article.

Yugoslavia reflects the influences of Eastern ideology from the years of Turkish occupation, the socialist political system, and the impact of U.S. financial support and technical assistance. Medicine is socialized in Yugoslavia and organized through the Communities of Health Insurance of industrial and agricultural workers and the Communities of Insurance of disabled and retired persons. The Federal Commission for Rehabilitation was founded in 1956 and the Federal Center for Rehabilitation originated in 1957 and later became an Institute. A national decentralization policy transferred administrative responsibilities for health services including rehabilitation to "republic forums and institutions" (*Godic, 1980*). However, since the extent of the development of the six republics vary from the industrialized cities to the agricultural-rural environment, the health services are uneven. The Institute of Mental Health was founded in Belgrade in 1963 which gave impetus to a new look at mental health care. Later a Center for Work Therapy and Vocational Rehabilitation was established that offered programs in carpentry, metal work, shoemaking, tailoring, and had a greenhouse for horticulture. Added to these activities were therapies such as: music therapy, fine arts and sculpture, and recreational therapy. (*Institute for Mental Health, 1972*)

Labor Exchange Offices maintained by the Employment Services are available in towns and cities. Unemployment compensation is funded through the compulsory percentage that is deducted from the worker's pay. To stimulate employment of the disabled, grants of $1,000 per worker per year are available to industry for salary support, equipment and work-environment modifications, new jobs, and so on. Inter-disciplinary teams (physician, social worker, psychologist, and counselor surrogate) staff the rehabilitation centers. Additional medical personnel are added to the team in medical rehabilitation centers. (*Carnes, 1979*)

Therapeutic communities involve both psychotherapeutic and socio-therapeutic approaches, work therapy, biologic therapy (ECT but not insulin). Medical, social and vocational rehabilitation services are designed to attain the maximum possible restoration of the psychiatrically disabled individual. Sheltered workshops, vocational evaluation and vocational placement are made available and ex-patients' Socio-Therapeutic Clubs contribute to the continuing rehabilitation of the patient in conjunction with the patient's family and friends. (*Institute for Mental Health, 1972*)

Yugoslavia realizes that problems exist because of the unevenness of its system in the various republics and also is aware of the need for professionally trained rehabilitation counselors. It is a land of many contrasts yet it maintains a desire for improvement and the acquisition of knowledge. (*Carnes, 1979*)

The *implications* derived from the survey of 19 countries of Europe may be ascribed, in part, to the differences in political framework even more than from the actual services offered. In those countries with a socialist ideology, medicine and other related services including rehabilitation for the mentally ill are distributed by the government. With the absence of private psychiatrists, it would seem that the deployment of mental health personnel would result in equality of health care services. However, this is not always accurate since those countries with developing industrialization and decentralization of administrative responsibilities do demonstrate unequal service opportunities. One of the points that was similar for all countries in Europe is that the term rehabilitation was utilized and usually specified for the psychiatrically disabled. However, the efficacy and the level of services varied considerably.

Funding priorities and insufficient professionally-trained rehabilitation personnel often were the barriers presented to implementation. Sometimes it was the legislation that encouraged disincentives to work by the structure of benefits or because the rights and services for mentally ill and mentally restored were not clearly and/or appropriately defined. In some instances the eligibility requirements and the vocational objectives eliminated certain disabled people from full realization of services. The credo that the traditional mental hospitals should be phased out did not occur although depopulation closed many hospital wards.

Innovative procedures could be identified and the following lists some of them:

- The "single-string" system in Denmark that places all authority for rehabilitation services under one authority in the public assistance offices.
- Sectorization of mental health services as established in France with mental health teams for sectors.
- Psychiatric care/counseling available on the job as in the Federal Republic of Germany.
- Comprehensive networks of services with psycho-social orientations as in the Federal Republic of Germany.
- Phasing out process of Trieste Mental Hospital, Italy with the concurrent origination of community services.
- The concept of the "lowest effective level of care" as proposed in Norway.
- Hospital associated community-oriented and work-oriented programs in Sweden.
- Joint employment of psychiatrically disabled with non-disabled persons in Sweden.
- An extensive planning and implementation of community-based services in England.
- Richmond Fellowship in England and its influence on the Fellowships established in other countries.

North America

North America is the third largest continent after Asia and Africa. The over nine million miles of North America include Canada, the United States, Mexico, Central America, the West Indies and Greenland. A kaleidoscope of differences are evident among the countries in political-economic frameworks, in educational levels, in sociolinguistics in racial/ethnic and other cultural characteristics. In some instances, this heterogeneity is reflected more sharply within the countries. The productive society that has developed, particularly in the United States and Canada, is rooted in a tradition of rugged individualism and two-fisted frontiersmen that has established stereotypes of the "good life" and the "work ethic." These notions have reinforced negative attitudes toward budgeting funds for those individuals who do not meet the conventional criteria of success. Industrialization and urbanization added further stressors to family systems changing the family structure from an extended to a nuclear system and frequently made the so-called "unfit" more difficult to handle. It is within this pendulum of favorable/unfavorable influences that the civil rights movements and legislative efforts have sought to obtain appropriate, adequate, accessible, and effective services.

Canada has a background of action that has emerged from the endeavors of voluntary organizations. Many of the organizations emerged at the time of World War I. These specialized organizations include the Canadian Mental Health Association. Coordination of these approximately 50 voluntary organizations was initiated with the founding of the Canadian Rehabilitation Council for the Disabled (CRCD). This Council seeks to avoid proliferation, duplication, and overlapping of funds. CRCD's Five-Year Plan initiated in 1976 sets targets for the development of technical aids for the disabled, housing, education, employment, transportation, income maintenance, recreation and cultural activities. The intent is to help disabled persons develop to their fullest potential.

A network of Rehabilitation Centers has been established in Canada and a Disability Allowance is provided based on a needs test. In order to encourage programs for the disabled, the Federal Government enacted the Canada Assistance Act that provides a 50/50 sharing of costs by the Federal Government and the Provincial Governments. The Vocational Rehabilitation of Disabled Persons act provides vocational rehabilitation services and some employment counseling is offered by the Manpower Department of the Federal Government. (*Dinsdale, 1978*)

Although many needs of disabled persons have not been met—particularly in employment, community living arrangements and community support systems, Canada has demonstrated progress in identifying gaps in services and in establishing rehabilitation as a priority issue. This issue has been stated as a global one for all the disabled rather than specifically the mentally ill. On a smaller individual scale, some interesting programs can be identified. Two of these are reported, as follows:

> *An innovative behavioral medicine program is underway at St. Joseph's Hospital in Hamilton, Ontario in which a psychologist performs the key role in planning for patients seen in a medical unit. The psychologist also integrates the various opinions from the medical specialists. Patients exhibiting chronic pain or a work-related disability are interviewed by a team consisting of an internist, psychiatrist, and a behaviorally trained psychologist. The psychologist from the Behavioral Medicine Unit visits the worker's place of employment and identifies the tasks involved. The psychologist compares this information with the patient's behavioral characteristics and the limitations imposed by the disabling condition. Adjustments are made in accordance with these factors. Workers are treated on an out-patient basis (as long as possible) rather than being hospitalized. The values of this program stem from early intervention, continuation in the community, avoidance of increasing disability, and averting of a more severe psychiatric disorder as an outcome of the stress experienced.* (APA Monitor, 1980)

> *At the Royal Jubilee Hospital in British Columbia, Canada, the family is used as a primary resource to rehabilitate chronically ill psychiatric patients. This program also takes into consideration the iatrongenic illness to which physicians and other hospital personnel contribute by reinforcing the sick role and dependent behavior. The game of "Help" is described to mental health personnel as the symbolic expression of the roles that the personnel perform in establishing, reinforcing and prolonging the "illness" rather than the "wellness" of the hospitalized patient.* (Ney, 1976)

A description of the rehabilitation of the mentally ill in the **United States** is in itself a study in cultural diversity. The heterogeneity of the U.S. planning and implementing of rehabilitation programs varies among the fifty states: within the states dissimilarities emerging from socio-economic factors, language differences and other racial/ethnic and medical traditions entail a complexity of adjustments. Adaptations to this variability is demonstrated in the following examples:

- In Boston's Chinatown in which Chinese-speaking and cultural knowledgeable mental health workers are incorporated in the multi-disciplinary team providing treatment/rehabilitation in a mental health clinic in Chinatown. (*Gaw, 1975; Freiden and Ho, 1978*)
- In a barrio-neighborhood mental health service for Mexican-Americans in Arizona, a study revealed some of the factors that made for abbreviated use of mental health services by the Mexican-American people. The findings of this study were used to change procedures in order to encourage clients to continue receiving needed services.

- In the Hispanic Mental Health Project sponsored by the Philadelphia County MH/MR Office, a study of the city's Spanish-speaking population, most of whom are Puerto Rican, demonstrated that more needs to be done to provide accessible services to the Hispanic community. One of the findings was that the residents preferred Spanish-speaking workers at the clinic. A bilingual clinic staff and other changes were integrated into both county-level and local service agency planning in order to increase the utilization rates of MH services in the community. (*Currents, 1979c*)

- In Southern California, for the past several years, beliefs similar to Burmese supernaturalism and witchcraft have become part of the mental health practices of selected groups. (*Spiro, 1975*)

In essence, the United States has a pluralistic cultural population and a pluralistic mental health care system. Furthermore, problems of information and *mis*information persist and are often intensified by garbled half-truths in the media. (Brown, 1977) The magnitude of the problem has been recognized at various levels of government and among many of the "grass-roots" voluntary organizations as well as the spreading self-help groups.

There are vocal advocates in the United States Congress urging improvements and several Presidents of the U.S. have turned their attention to deinstitutionalization, community care and rehabilitation. The Honorable Charles McC Mathias, Jr., United States Senator is one of the persons at the national level who has spoken of his concern for the needs of the disabled. At the fiftieth anniversary of the National Rehabilitation Association, in 1975, Senator Mathias commented about the urgency of removing physical and psychological barriers so that the disabled might be able to lead fuller and more meaningful lives. The Senator also mentioned his efforts to expand the federal budgetary allotments for rehabilitation by increasing the Innovation and Expansion Grants of the Rehabilitation Act of 1973, as amended. (*Mathias, 1976*)

There have been signs of progress in the rehabilitation programs since the initiation of the U.S. national rehabilitation program in 1920 with the Smith-Fess Act. Prior to that Act, several states had vocational rehabilitation statutes as part of workmen's compensation laws which allowed benefits only for work connected disabilities. (*Shoob, 1978*) However, within recent years the psychiatrically disabled* have been the subject of increasing discussion in rehabilitation programming.

The President's Commission on Mental Health (PCMH) was established by Executive Order No. 11973 signed by President Carter in 1977. The objective of this Order was a review of the mental health needs of the people of the United States and the efficacy of the existing methods of meeting these needs. The findings of this Commission are contained in four volumes. The following briefly summarize the statements in the Report to the President from the Commission's fact-finding task panels. (*PCMH, 1978a*)

The Commission finds that mental health services in America has made progress in seeking to make available mental health care of high quality at reasonable cost, yet . . .

- The mental health service system which currently exists is still in a state of evolution. It combines public and private personnel, facilities, and financing without clearly established lines of responsibility or accountability. For some Americans this system presents few problems since they are able to obtain the care they need. However, too many Americans remain unserved, underserved, or inappropriately served because of where they live, financial barriers, or because the services available to them are limited or not sufficiently responsive to their individual circumstances.

One important recommendation from the Commission was for the development of a national plan by the Department of Health, Education and Welfare (HEW),* in consultation with State and local governments that would address itself to the following goals: minimize the need for institutional care; assure high quality care for those who must be institutionalized; provide after-care services and alternatives to hospitalization in the community; provide retraining and job placement for personnel displaced by the phasedown process; and encourage the use of State hospitals for human service activities. This plan is to be an action plan rather than a theoretical treatise or another survey. It should provide statements of commitment by the States and the Federal Government about roles and responsibilities. (*PCMH, 1978a*) Thus the progression from the 1977 Report to the Congress by the Comptroller General of the United States (General Accounting Office-GAO) "Returning the Mentally Disabled to the Community: Government Needs to Do More"—to—the 1977 HEW Task Force on Deinstitutionalization of the Mentally Disabled—to—the Reports from PCMH in 1978—is currently being formulated into a National Plan for the Chronically Mentally Ill to be completed by August, 1980. The chronically mentally ill for whom this National Plan is to be designed are defined as "individuals who are, have been, or in earlier times might have been residents of state mental hospitals and who are intended to benefit from the shift to community-based care. (*PCMH, 1978a*)

*A report from the Joint Commission on Mental Illness and Health was published in 1961 which emphasized community-based services and a reduction in size of hospital population, and, where appropriate, the closing of large State hospitals. The Mental Retardation Facilities and Community Mental Health Centers Act of 1963, plus subsequent amendments, provided the programmatic vehicle for establishing a network of publicly funded community mental health centers throughout the country. (*PCMH, 1978a*)

*HEW is currently partitioned into two separate departments—The Department of Health and Human Services and the Department of Education.

As part of the considerations of this National Plan, the concept of least restrictive environment is to be clarified with emphasis on the individual's level of functioning, cultural orientation and specific needs. Locus of care is important among the multi-dimensional variables determining the least restrictive environment but unlike other disabilities psycho-social problems are intrinsic to the disability. Thus considerations of intrapsychic and interpersonal difficulties come first.

The 1978 amendments to the Rehabilitation Act of 1973 are just part of the more pronounced realization that the psychiatrically disabled should be included in rehabilitation plans. It is evident that there is a growing awareness that services must be planned within an interdependent system—community residence must have a social component plus vocational, income, and leisure goals. Legislation has recently been passed that reflects the Federal Government's attention to community services. For examples:

- The enactment in 1978 of the Housing and Community Development Act Amendments and the Housing and Urban Development's (HUD) 1979 appropriations bill. Together these enabled HUD to allocate substantial sums of money for the housing needs of the non-elderly handicapped. A special note appended to Section 202 of HUD's legislation supports the purchase and renovation of congregate living and apartment facilities for the chronically mentally ill and HUD's Section 8 adds rental subsidies and other personal assistance services to housing.
- The Community Mental Health Center (CMHC) Extension Act of 1978 re-authorizes the CMHC program for two more years specifying the six services required to start a new CMHC and six additional services to be phased in over three years. For the first time the CMHC legislation mandated residential services.
- The Community Support Program (CSP) launched by the National Institute of Mental Health in 1978 has activated a renewed emphasis on residential care and encouraged greater coordination of existing community services. New sources of programmatic support have been developed through the Rehabilitation Services Administration and the Department of Housing and Urban Development. (*Currents, 1979b; Turner and TenHoor, 1978*)
- The National Institute of Handicapped Research (NIHR) was established by Public Law 95-602 in 1978 to coordinate a variety of federal programs into a more cohesive effort aimed toward the beginning of a national program, to bring science and technology to handicapped persons. A statutory council, the National Council on the Handicapped is to be formed with membership of one-third handicapped persons or parents of handicapped children, one-third professionals and one-third lay people representing the public. This Council would have overview authority over NIHR.

The right to work and vocational rehabilitation are a significant aspect of rehabilitation. Section 503 and 504 of the Rehabilitation Act of 1973 as amended are affirmative action sections that strengthen the disabled person's right to work as well as, by implication, the right to choose whether he should disclose former mental illness. In addition to this legislation, encouragement of employment of the mentally restored and other disabled persons is offered through national, state and local committees and agencies. The President's Committee on Employment of the Handicapped (PCEH) through its publications (*PCEH, 1977; 1978*), its Annual Meetings, and state and county committees publicizes the benefits of employing the mentally restored. The Federal Veteran's Administration Rehabilitation Act of 1943 provides subsistence, tuition and other necessities for training disabled veterans. (*Psychiatric Evaluation Project, 1962a; 1962b*) The CSP through its "Learning Community" conferences and through plans for a National Technical Assistance Workshop is enlisting a group of mental health professionals, consumers, and government and community representatives. This group is to establish procedures through various communication channels that reduce the stigma associated with mental illness so that their community care will become more acceptable. (*Long, 1979*)

Several non-governmental organizations and governmental agencies have been influential in encouraging legislation, in establishing services for the mentally ill, and in the initiation of innovative approaches. Some of these are as follows:

- The National Association for Mental Health (NAMH) has been a strong advocate for the rights of the mentally ill and has supported the expansion of community services, research, preventive measures and rehabilitation. NAMH also disseminates literature for public and professional information about mental health and mental illness.
- Horizon House Institute in Philadelphia has training and research programs as well as residential opportunities. The Institute publishes a periodical "Currents" which reviews innovative mental health and mental retardation programs.
- Fountain House in New York City has been the prototype for many other similar Houses established in the United States and in some foreign countries such as in Lahore, Pakistan. Horizon House and Fountain House are two of the largest and most comprehensive programs. Fountain House has a residential program, psycho-social program, pre-vocational and vocational programs, and conducts training and research as well as offers nationwide consultation. Its Transitional Employment Program (TEP) is described in the Lahore, Pakistan Fountain House survey. (*Beard, 1976; Robinault and Weisinger, 1979*)
- The Rockland Research Institute in Orangeburg, New York has developed a computerized Drug Ordering System and a Medication Order Review and Evaluation System (MORES). (*Bank, 1980*)
- Partial hospitalization services have been expanded at the Dutchess County Mental Health Center in Poughkeepsie, New York so that patients may attend programs in the daytime, evening and the weekends and return home at night. (*This Month, 1980*)

- A Psychiatric Emergency Home Visiting Team represents a unique approach to the community treatment of mental illness. Telephone requests bring two trained personnel to the home to assist in a crisis situation and individuals are referred for further treatment if needed. (*Steer, et al, 1979*)
- Health Maintenance Organizations (HMO's) are expanding their attention to the behavioral aspects of health through such activities as increasing the patient's self-awareness of psychosocial skills and providing training in coping skills. (*Kelty, 1979*)
- Employee Assistance Programs (EAP's) are increasing among large business organizations and in the federal government. Some smaller businesses are forming consortiums so that EAP's may be shared. The fundamental belief of the EAP's is that anything that affects job performance is a criterion for treatment. Thus this program covers a wide range of problems. (*Brasch, 1980*)
- The ICD Rehabilitation and Research Center in New York City is a non-profit center that includes rehabilitation research, professional education and comprehensive out-patient services including a Placement Preparation Program for all disabled persons including the psychiatrically disabled. It has pioneered numerous approaches to rehabilitation including testing procedures such as: Micro-TOWER (*Backram, Undated*) and TOWER (*Rosenberg, 1977*). ICD publishes informational pamphlets and other literature as well as a Program Evaluation Newsletter. Recently its research center published the third edition of its handbook "Mobilization of Community Resources: A Multifacet Model for Rehabilitation of Post-Hospitalized Mentally Ill." (*Robinault, and Weisinger, 1979*).

From the custodial care of the one existing psychiatric hospital, **Cuba*** has developed a free-of-charge mental health service network of institutional and community services that seek to be responsive to the people's needs. This system is integrated into the public health continuum of health services; and, thus, the public health model is the foundation for services to the psychiatrically disabled. Confronted by the exodus of technicians in the early 1960's, the Cuban government supported the training of psychologists, psychometricians, and psychiatrists so that the number of trained mental health personnel has increased tremendously. However, even with this increase the health personnel, and particularly the mental health personnel, are insufficient for the needs of full services to all people. Future plans are targeted to doubling the number of psychiatrists and psychologists. The study of psychiatry and psychology has been integrated into the entire medical school curriculum as an essential element in medical practice. Thus general physicians emerge with some knowledge and skills that help them in recognizing psychological disturbances in their patients. Throughout the six years in medical school, all students also study Marxism-Leninism and those who specialize in psychiatry take additional courses in this theory to better understand its role in the socio-economic factors influenceing behavior.

The mental health system is still evolving and moving toward synthesis with Cuba's socialist ideology. An understanding of the interdependence of the Cuban mental health system within the Cuban society requires information about the political and administrative organization as well as the social structure. Camayd-Freixas and Uriarte (1978) present an explanation in their paper about Cuba's mental health system.

The notable characteristics of this system is that health services are the *right* of every individual and the state's responsibility. Among other goals, the network of services must serve as prevention, rehabilitation and education with proactive rather than reactive planning. The community actively participates in this planning through its organizations.

Primary health care is organized according to sectorization with a core team consisting of a physician and a nurse who are based in a polyclinic. The polyclinics are also organized according to sectors responsible for specific neighborhoods. Each core team is responsible for several hundred people in their health area and although based in the polyclinic, the team travels within the community visiting individuals, schools, work centers, and community institutions. The system of "dispensarization" identifies high-risk groups and assigns them a minimum number of annual visits for which the core team is responsible. Inter-disciplinary mental health teams (psychiatrists, psychologists, psychiatric nurses, social workers) are consultants for the core teams. However, because of the personnel shortages polyclinics often must share mental health teams. Health personnel update their knowledge and skills by means of frequent inservice training seminars and also profit from regular feedback about the patients' progress.

Majorra Hospital (Psychiatric Hospital of La Habana) was established in 1864 and served as the main resource for the mentally ill. This custodial institution was a filthy, jail-like structure, a "snake-pit" with naked patients fed from large pails on the floor. The major causes of death of the patients were bacillary dysentary and malnutrition. Until 1959, when a new Director was appointed, twenty percent of the patients died annually. The Director improved the hospital's hygienic procedures and its physical environment and instituted more nutritional meals served in a humane atmosphere. By 1960 the death rate dropped to two percent annually. The Hospital serves as both one of the regional hospitals as part of the continuum of health services and as a national psychiatric hospital for teaching, training, and consultation.

*Discussion of Cuba's mental health service system is based on Camayd-Freixas and Uriarte, 1978; Crain, 1978; and MINSIP, 1971.

About 70% of the patients at Majora are schizophrenic. The hospital has a staff of approximately 1800 with the largest staffing pool of 250 in the Occupational Therapy and Rehabilitation Department. Patients become involved in the homelike therapeutic community for rehabilitation and resocialization from the moment of their admission. There are six levels in the rehabilitation program. The process begins with an assessment of the patient's rehabilitation potential by a multidisciplinary team. From these findings a treatment plan originates and the rehabilitation level for the onset of the program is determined.

The first three levels of the rehabilitative process concentrate on hospital procedures that maintain the patient in or near his room; the last three move the patient into the community gradually with more and more responsibility and freedom. Occupational therapy begins during the second level and continues in the third level and patients are paid for their work with an additional stipend to maintain their ties with their families. During the fourth level patients work outside of the hospital in sheltered workshops or at a special job site. More intensive social rehabilitation is begun during this time. When the patient makes sufficient progress at the fifth level he is placed in a residential rehabilitation center (similar to a half-way house) and is exposed and assisted to cope with a collective living experience that includes work, recreation, and living arrangements. Finally, in the sixth level, the patient returns home and is employed in a regular work center. The patient's treatment team works with the family, neighbors and co-workers and others to ease the social reintegration of the former patient.

Ergotherapy is defined as any activity that may be used constructively to help patients gain their general abilities and through this improved functioning be able to gain their place in society. Work is therefore a therapeutic technique, an aspect of ergotherapy which is part of occupational therapy. Other aspects of the treatment/rehabilitation program includes individual, group and family therapy, chemotherapy and ECT. The individualized program considers each patient a bio-sociopsychological individual and in addition to the Marxist principles; the major theoretical orientation is an eclectic behaviorism.

Two innovative techniques use resources not often utilized with the psychiatrically disabled:

- "Movie debate"* is a form of group therapy that was developed with the Cuban Institute of Art and Cinematographic Industries (CIACI). A mental health clinician uses films produced by CIACI about issues related to family crises, marital conflict, child rearing, and the like as bases for discussion and resolution of patients' problems.
- Psychoballet is used primarily with children as a tension-releasing method through physical activity within opportunities for creative expressions of fantasy.

*"Cinema anti-therapy" is a therapeutic modality in the United States, described by Fesenmaier; "cinema therapy" by Herzog in West Germany has been used for a long period of time; and Grassett, a psychiatrist, has classified films in terms of their usefulness in psychology and psychiatry (Behavior Today, 11(26), 1980, 6).

Another innovative procedure is demonstrated in those Day Hospitals which assign the psychiatric patients to the administrative staff of the general hospital. These patients have employee cards, a work assignment for half the day, eat at the staff restaurant and spend the rest of the day in the adjacent day hospital where they are offered psychotherapy as well as occupational and recreational therapies. Staff members rotate through the day hospitals, the out-patients departments and also maintain contact with the patients as they move into the community. Follow-up and prevention become a cooperative effort of the mental health personnel and the family since contact continues with all significant persons as long as necessary.

The joint efforts of the National Mental Health Group with the Ministry of Public Health gives direction to "psychiatry in the community." The Cuban Government realizes that its ideals for an integrated public health service system has the outline for services that can only be fulfilled with an expanding personnel.

Mexico, a Federal-Republic, is a land of sharp contrasts. Urbanization and modernization are contraposed with isolated areas that are rural and traditionally-oriented. Dissimilarities are apparent between the museum-rich cities such as Mexico City, the resort attractions such as Aculpulco, and the outlying areas with thatched huts in which large families share one room and outdoor toileting. Communication barriers exist even among the native inhabitants because of their language/dialect differences. These difficulties are exacerbated due to areas isolated by the geographical features of the uneven terrain and the rigors of climatological conditions. Health services are provided by physicians and other health personnel some of whom have been educated at universities and medical schools in the United States, others in Mexican universities, or still others trained as curanderos (folk healers). A large proportion of the population are too far removed from the available urban health systems to have access to rehabilitation services or even to obtain information about governmental benefits.

The variation in subcultural characteristics is reflected in the acceptance or rejection of modern treatment/rehabilitation practices by the Mexican people. Suspicion of the foreign-trained mental health workers and distrust of the white-establishment agencies is demonstrated in the Mexican villages and continues to affect those Mexicans who relocate in the United States. This skepticism is exemplified among the Mexican-American patients who visit a modern university hospital clinic in San Diego and also seek treatment from curanderos in the nearby traditional medical clinic (*Kleinman, 1975; De Rios and Feldman, 1977; Hernandez-Crozco and Deutsch, 1980*).

Rehabilitation services in Mexico are provided as part of the public health system. Both public and private institutions are coordinated by the Department of Health and Welfare. The groups for whom rehabilitation is most often described are those with hearing, language, or learning difficulties, the mentally retarded, and the "social invalids" with inadequate incomes, living arrangements and working conditions.

The particularism of some of the more geographically and culturally segregated Mexican people is reflected in their folk healing methods. The history of their methods of health care describes aboriginal customs of ritual confessions to their native chiefs (caciques) or shamans. This form of cathartic therapy has provided tension-reduction for the patient as well as the family, particularly since such confession had to be made or the "sick person might die." Peyote vomiting often has been a pre-stage of confession symbolizing the bodily expression of the later confession and the expulsion of the "poison of sin." Among some Mexicans, after confession, the sins have been "cast into a scapegoat", an animal or a person, which has been sacrificed (*La Barre, 1964*). Rehabilitation, therefore, has relied upon the projection of the "evil" by means of these healing processes. When such "cleansing" has occurred the sick person has been expected to become well and socially reintegrated.

Since the background of exacting folk-healing convictions persists among some of the Mexican people they often consider modern health care methods alien or strange. Therefore, it is the task of the Mexican government to discover procedures that would diminish the chasms created by these subcultural conditions and geographical distances. Other problems such as an insufficient number of trained physicians, psychologists, and technicians detract from the efficacy of the provisions of rehabilitative services. The Mexican government proposes the establishment of a National Rehabilitation Council to construct a national plan with administrative arrangements for the disabled. This Council will be charged with responsibility to formulate policies for prevention, research, rehabilitation, and the like. These programs must deal more effectively with the wide spectrum of subcultural differences and geographic hindrances. The control and implementation of the Council's national policies will be decentralized to state councils (*Hernandez-Orozco and Deutsch, 1980*).

South America

South America, the fourth largest continent, is spread over almost one-seventh of the earth's land area. Since the major portion of the continent is south of the equator, the winter months occur from June to August and the summer season begins about December lasting until February. The Andes mountains are replete with minerals yet are barriers to communication, transportation, and the development of the interior of the continent. Thus, although South America is rich in mineral resources, many inhabitants are impoverished. Men and often women and children work together as tenant farmers on the farms and plantations of the wealthy landowners. The coasts are beautified by attractive parks, broad boulevards and contemporary buildings which are the antithesis of the one-room wooden, mud or sun-baked clay (adobe) huts that line the unpaved streets of the country villages. Even though all South American countries provide free elementary school education, illiteracy is rampant among village dwellers who are also victims of poor diets and frequent illnesses. The Roman Catholic religion is recognized as the official national church in several of the countries, yet all South American countries permit freedom of religion. Inflation, political unrest and revolutions have been part of the continuing history of South America.

The progression in **Chile** from the traditional healing ceremonies by machis (witch-doctors) to more modern medical care has been accomplished through the training of health workers. In 1974, the National Health Service established training courses for health auxiliaries in various remote villages. One of these villages was Casa de Piedra, an example of a remote area in which machis, often women, prayed and healed the sick with special ceremonies. The machis "spoke with God" and when some one was ill, would sleep with an article of the person's clothing to find out the cause of the illness. The ceremonies such as the guillatun (rain-ceremony) continue as "charming fiestas," demonstrating a belief in God. However, an eight-month course prepares the health auxiliary to serve the 1,800 people in the Casa de Piedro sector. The salient point of this arrangement is that these persons are part of the culture of the area and have experienced, directly or through their family, the various machi ceremonies. Thus they are able to relate to the people while educating them about health problems. Availability and accessibility encourage primary health care (*Huenuman, 1977*).

In **Peru**, the health auxiliary is elected by the community. Local inhabitants in the Peruvian Altiplano of Puna cannot afford fare nor can they manage the doctors' fees. Instead, they patronize traditional healers who use incantations, occasional sacrifices and herbal remedies. The Peruvian government selected Puna as the location for an integrated approach as part of the national health development plan and arranged for the training of primary health workers. These workers who spoke the local language became the key element in the coverage of health services. The community decided on the fees to be paid for the health workers' services and also participated in erecting a building to serve as a health post. Auxiliary health workers refer patients whose problems are beyond their competence to the nearest health center where professional assistance is available. In addition to the initial training, these workers are under the supervision of professionals and of the people in the community who can refuse to reelect them the succeeding year. They are supplied a "Health Auxiliary's Manual" which provides a guide to health

problems in simple language with illustrations. This Manual recommends a cooperative relationship with the healers so that patients whom the healer cannot cure would be referred to the health worker. Health workers must attend refresher courses regularly to update their knowledge (*Harrison, 1977*).

In Summary

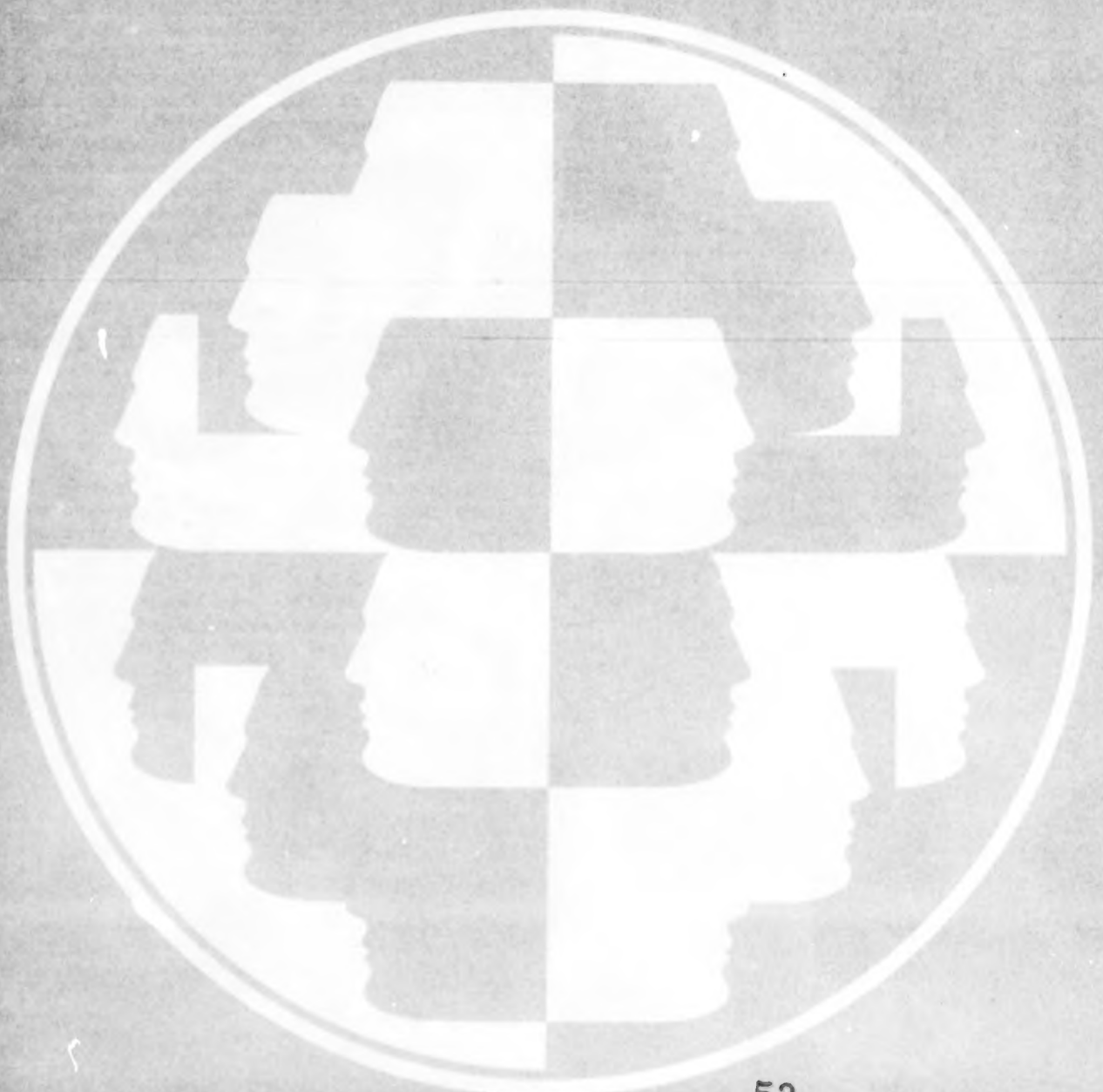
A theme flows through the health service system in North America and South America; and a similar theme can be noted throughout the over sixty countries described in this monograph—culture is the infrastructure that organizes perceptions and behavior. Consequently, cultural change that would influence the rehabilitation of the mentally ill must recognize the existing traditions of healing. This viewpoint underlines folk medicine as part of the support network that decreases the traumatic reactions and reluctance to accept contemporary procedures and eventuate in a broader texture of rehabilitative processes. The lesson to be learned from the survey of existing procedures is that cultural confidence must be safeguarded.

There are five essential *implications* for *rehabilitation of the mentally ill* derived from the comments about North America and South America that are applicable to other continents, as follows:

1. Curative measures supersede and are separated from considerations of the rehabilitation of the mentally ill in most countries. The prevailing view, too often, is that diminishing bizarre behavior should be the first (and last) "order of business." If rehabilitation is mentioned it is lower down in the priority list. Yet, this means that the *mentally restored* are *not socially prepared*.
2. Socioeconomic and political systems are crucial variables in the organization and administration of mental health services as well as the priority allotted these services.
3. Terrain and climate impact on the accessibility of services, transportation to services, and ease of communication of governmental benefits.
4. Westernization of rehabilitative practices can have a disastrous impact if local/personal traditions are ignored.
5. The health staffing pool need not depend solely on psychiatrists, psychologists, social workers and other mental health professionals. Shamans are part of the world's oldest profession and with suitable approaches can be integrated into mental health services plans in accordance with local mores. In addition, indigenous health auxiliaries can be trained to recognize the early characteristics of behavior disorder. Thus treatment and rehabilitation of the psychiatrically disabled could be incorporated into a core of knowledge and skills for these workers.

The preceding implications present a broad outline of the present. The next section seeks directions for the future. In itself, deinstitutionalization with the shifting of the locus of care has not been sufficient. As stated in the USA Joint Commission on Mental Illness and Health 1961 report, "Action for Mental Health"—"A national mental health program should recognize that major mental illness is the core problem and unfinished business of the mental health movement." Both the developed and the developing countries have generated concepts and programs but generally have moved sporadically and often incompletely into an ideology supporting linkages of community programming with state hospitals, with after-care services, and with articulation of state and local systems as well as private and public services. In fact, the processes have surfaced for rehabilitation of the mentally ill but the coalition of efforts have not materialized. The question remains—what are the directions that are appearing and that should appear to bolster a mental health program focused on the chronically mentally ill that also would improve mental health services for everyone?

Part Three: The Future
Directions for Rehabilitation of the Mentally Ill



The study of cultural differences of treatment/rehabilitation of the mentally ill from an international perspective provides some important insights that are crucial to the cultural pluralism of nations such as the United States. Though brief and uneven in coverage, the survey in this monograph supports the desirability of international collaboration. There are issues of similar concern in most nations, for example, human rights. International concern has been expressed about the abuses to human rights that emerge from the blatant harassment, detention and torture of persons and the invisible barriers erected by the stereotypes and myths about mental illness as well as other disabilities.

I. Collaborative Efforts—Internal International Organization

International collaboration has attempted to orchestrate efforts to alleviate some of the bases for concern. Such efforts became especially apparent after the World Wars. For instance, the International Labour Organization was established soon after World War I and the United Nations after World War II.

The **International Labour Organization (ILO)** was created in 1919 at the same time as the League of Nations. It was directed to set up international collaboration for the study of labor problems and for the adoption of international standards for workers' protection. In 1946, it became the first specialized agency associated with the United Nations. The scope of ILO's activity was enlarged in 1944 and again in 1946 to include social international cooperation in the struggle against poverty and insecurity and in the exchange of technical information. Many recommendations have emerged from ILO's deliberations since its inception with Recommendation 99 (in 1955) presenting a comprehensive guideline for the development of services for the vocational rehabilitation of the disabled. This recommendation applies to all disabled persons regardless of the origin and nature of their disabilities; and the recommendations also emphasize that the rehabilitation services should be adapted to the needs and circumstances of each country. ILO's responsibility encompasses many functions among which are the International Institute for Labour Studies in Geneva, the International Labour Conference, publications, and the provision of grants and technical expertise. In relation to directions for the future, the ILO espouses coordination and cooperative approaches to the development of vocational rehabilitation activity on a global scale. These collaborative efforts are of singular importance as preparatory work for the United Nations International Year for Disabled Persons (IYDP) in 1981.

One of the major goals of IYDP is the promotion of international efforts to provide disabled persons with proper assistance, training, care and guidance to ensure full integration into society. In addition to promoting effective measures to assist disabled persons in their physical and psychological adjustment to society, IYDP will seek to educate and inform the public of the rights of disabled persons to participate in and contribute to various aspects of economic, social and political life.

The **United Nations** originated in 1945 with the World Health Organization (WHO) formed as one of its specialized agencies in 1948. The central office of WHO is in Geneva, Switzerland and six regional offices are spread throughout the globe. WHO has defined health as "a state of complete physical, mental and social well-being." A new subdivision, Division of Mental Health, was initiated in 1975. This Division emphasizes the public health and social aspects of mental health and encourages a reorientation in thinking about mental health. Rather than linking mental health only to mental diseases and exclusively to mental health professionals, mental health programs must operate in synergistic teamwork with multidisciplinary contributions from education, social welfare, labor and health sectors. In addition, mental health problems can be resolved with more proficiency in the processes of close cooperation and sharing of culturally and socially relevant technical information and skill. Some of the goals proposed for mental health programs are as follows: decentralization of mental health services to regional, district and community levels is encouraged and large mental hospitals are discouraged; inpatient and outpatient units should be linked to general medical facilities supported by community education and involvement in mental health services by means of such agencies as community mental health centers; and self-reliance in mental health programs on a national scale as well as individual self-reliance should be fostered. WHO's principal goal is "the enjoyment of a level of health by all the citizens of the world by the year 2000 that will be conducive to a high social and economic productivity."

There are several other international organizations concerned with rehabilitation which either focus partially or entirely on mental illness or mental health, as follows:*

Council of Europe, Strasbourg, France.

Council of World Organizations Interested in the Handicapped (CWOIH), New York, N.Y., USA.

International Association of Workers for Maladjusted Children, Paris, France.

International Committee Against Mental Illness (ICAMI), New York, N.Y., USA

International Council of Goodwill Industries of America, Washington, D.C., USA. Member organizations in Canada, Central America, South America, Africa and Australia.

International Institute for Rehabilitation, Tehran, Iran.

International Conference on Self-Help Mutual Aid in Contemporary Society, Alfred H. Katz, DSW, Professor of Public Health, University of California, Los Angeles, California, USA.

International Social Security Association (ISSA), Geneva, Switzerland.

The New World Foundations, New York, N.Y., USA (Community self-help project)

Partners of the Americas Rehabilitation Education Programs (PREP), Washington, D.C., USA. People to People program between the United States and Latin America and the Caribbean.

People to People Committee for the Handicapped, Washington, D.C., USA.

International Rehabilitation—Special Education Network (IRSEN), Louisiana State University, Baton Rouge, Louisiana, USA. A primary objective of IRSEN is to promote a mutually beneficial relationship among domestic and international academic institutions and agencies associated with rehabilitation and special education through research, information, training, extension for the improvement and delivery of services to the physically, mentally and socially disadvantaged throughout the world.

Fogarty International Center, National Institute of Health, Washington, D.C , USA. Studies foreign medical systems, cooperates with other nations in information exchange and in the production of new medical findings, conducts an International Education Program and also an International Research Program that enables American health professionals to study abroad.

Rehabilitation International, New York, N.Y., USA.

Rehabilitation International, USA, New York, N.Y., USA.

Rehabilitation Services Administration, Department of Education, Washington, D.C., USA. International activities include: cooperative international research and research utilization, interchange of experts, training and manpower development, technical assistance, information exchange, bilateral agreements, advisory services to US and international organizations and agencies.

University Centers for International Rehabilitation, Michigan State University, East Lansing, Michigan, USA. Publishes books, articles and newsletters about rehabilitation and operates international programs that share research, information, training and evaluations procedures.

United Nations Educational, Scientific and Cultural Organization, Paris, France.

World Federation for Mental Health (WFMH), The University of British Columbia, Vancouver, B.C.

*Listed in one or more of following: *Compendium of the CWOIH, 1977-1978*, New York, N.Y.: Rehabilitation International: *Directory of Organizations Interested in the Handicapped, Rehabilitation Worldwide*, Washington, D.C.: President's Committee on Employment of the Handicapped.

The aforementioned list is not meant to be exhaustive but merely to represent some idea about the sources for information and the kinds of programs emphasized. An examination of the titles of the listed organizations might lead to the conjecture about the desirability, even the necessity, for the affirmation of rehabilitation of the mentally ill to urge the inclusion of rehabilitative processes. There is a polarization of viewpoints concerning whether treatment and rehabilitation should be separated in discussion and in practice. In discussion, should rehabilitation be identified since the gamut of psychosocial procedures so often are omitted? In practice, should treatment and rehabilitation be considered as separated processes or as part of the patterning of mental health services? The response to these questions would be simple within an ideology that emphasizes caring and preserving the right to social reintegration.

There are many obstacles to the implementation of services. Stereotypes and myths emerging from negative attitudes toward mental illness hinder the adequate provision of preventive services as well as the community integration of the mentally restored. The public does not recognize that mental disorders are widespread and that many of the symptoms can be effectively treated. Even among the medical undergraduates, general practitioners, and health administrators there is a severe lack of accurate information about mental illness. Confusion about the differentiation between mental illness and mental retardation adds to this paucity of knowledge. There also is misunderstanding about the relative cost of community versus institutional care for the mentally ill. A study of these costs by Bisogno, et al (1979)* concluded that ". . . it is clear that the cost of providing a full range of community support services is less costly to the taxpayer than is the comparable cost of providing the same services in a state psychiatric center." The annual cost of maintaining a patient in a New York State psychiatric center is about $30,000. Patients can be cared for in the community for less than half that amount.

*Bisogno, J., et al, The public cost of treating the chronically mentally ill in the community, Ripple, New York State Office of Mental Health, 16, Oct, 1979, 1-4.

II. In Summary— The Dimensions of Rehabilition

The future for the rehabilitation of the mentally ill is energized by the demand for full civil rights for the mentally ill. Services must be adapted to the social and cultural factors of various ethnic, minority and other cultural groups. There must be coordination and clarity of policies and responsibilities for the funding and implementation of services among governmental and nongovernmental agencies. Patients as well as their families should be utilized, whenever feasible, in the prevention, planning, treatment, and rehabilitative processes. Community education must make visible the available programs; and advocacy programs for and with the patients should become part of the educative process. Training programs should be expanded or established for a wider number of persons including but extending beyond professional mental health workers. This training should include self-help groups, beginning professionals (paraprofessionals), and family members. Volunteers should be mobilized as case aides, should be used creatively and should be part of the training program. Income maintenance and other financial needs, job opportunities, housing and leisure opportunities should be provided as part of the continuity of services.

These proposals seem idealistic and yet can be proven to be cost-effective in the long run. Implementation of these thoughts would lead to the egalitarian relationships—the responsibility for decision-making and the control of the process of rehabilitation would be shared among clients, families and professionals. Even further, it would alter the emphasis to an ecological perspective that views an individual within the context of family, community and the broader international networks affecting behavior.

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